bhsi

BEHAVIORAL HEALTH SCIENCES INSTITUTE

SCHOOL-BASED BEHAVIORAL HEALTH PROFESSIONAL

COURSE BOOK

Prepared for:

The Department of Education

Prepared by:

The Behavioral Health Sciences Institute
A Collaboration of Spurwink Services and University of Maine at Augusta

)0 Riverside Street, Suite A4, Portland, ME 04103
-4018 • EMail: info@bhsi.net • Website: www.bhsi.net

Table of Contents

Module 1:
Introduction to School-Based Behavioral Health Professional

bhsi

BEHAVIORAL HEALTH SCIENCES INSTITUTE

1

Module 1 —

Introduction to School-Based

Behavioral Health Professional

Activities

Activity 1: Reporting

Generate a class discussion about mandatory reporting. If possible, draw from experiences of students in the class. Or, use one of the following scenarios to generate a class discussion.

1. A BHP has been working with a nine-year-old girl for three months. During the past 2 weeks she has been more withdrawn and emotionally volatile. The BHP walks into the child's classroom and sees her sticking a pencil in the groin of a male doll. What should the BHP do next?

2. For the past 3 months, the BHP has been working with Mike, a 6-year-old with serious behavior problems. The BHP noticed a red mark on Mike's neck and Judy, his mother, remarked that he ran into the clothesline while playing in the yard. Later, Mike tells you that his mother "squeezed" his neck. The BHP likes Judy and feels she is a good mother who is trying hard under difficult circumstances. What should the BHP do?

What's the Point? To give the students an opportunity to explore the complexities of assessing for reasonable cause to report and discuss concerns about reporting

Activity 2: Self-Awareness

Break the class into groups of 3 – 5. Ask them to list five things in each of the quadrants. Give an example for Unknown Self – rage or hatred and Blind Self. Reconvene the class and write their responses in 4 quadrants on a flip chart or white board. Generate a discussion. Questions you might ask:

- What surprised you?
- What are you curious about?
- What is unsettling?
- What did you learn about yourself?

What's the Point? To give the students a way to begin to think about and explore self-awareness

Activity 3: Problem Solving

Break the class into small groups of 4 – 5 people. Give each group one of the following scenarios (these come from the "lived experiences of BHP's"), or draw from the experiences of people in the class. Ask the group to define the problem, determine options, select an action, and discuss how they would evaluate the results.

1. Jimmy's parents are getting a divorce and Jimmy has been acting out in class because his Dad no longer drops him off at school. Today, his mother's boyfriend dropped him off this morning. Jimmy walks into the classroom and seems sad. He refuses to listen to the BHP and work on his goals. He throws his backpack and almost hits another student and yells, "Leave me the #$&* alone!"

2. Barbara had a temper tantrum while out in the community. At first I ignored it and then redirected her to another activity. She engaged in the new activity but appeared to be bored. When we returned school, Barbara complained to her teacher that I never let her get her way. The teacher acts frustrated towards me and Barbara refused to work on her goal for the rest of the day.

What's the Point? To give the students an opportunity to practice problem solving

bhsi

BEHAVIORAL HEALTH SCIENCES INSTITUTE

1

Module 1 —

Introduction to School-Based

Behavioral Health Professional

Content

Module 1 – Introduction to School-Based Behavioral Health Professional

Overview

This module sets the tone for the modules that follow by addressing why children and families need the services of a School-Based Behavioral Health Professional (SB-BHP). This module includes information about the inherent value placed on children, families, and people with disabilities; the roles and responsibilities of the SB-BHP; the legal and regulatory requirements governing the delivery of these services; and problem solving.

Competencies

A The participant will demonstrate an understanding of values related to working with children who are recipients of school-based behavioral health services.
(Level 1)

B The participant will demonstrate an understanding of SB-BHP roles, responsibilities and legal and regulatory requirements including mandatory reporting of abuse and neglect.
(Level 1)

C The participant will demonstrate an understanding of disabilities, including the effects of the disabilities on the child, and community attitudes towards children with disabilities and their families.
(Level 1)

D The participant will demonstrate the ability to solve problems related to the delivery of school-based behavioral health services.
(Level 2)

F The participant will demonstrate an understanding of teamwork.
(Level 2**)**

Competency

A The participant will demonstrate an understanding of values related to working with children who are recipients of school-based behavioral health services, and their families. (Level 1)

THE WORK

The main focus of the SB-BHP's work is to help the child to increase his/her overall level of functioning through skill development and the promotion of adaptive behaviors. One of the ways you will help to increase a child's skill development and adaptive behaviors is by developing a working alliance with the child that is based on his/her strengths and goals. A part of your responsibility as a member of a treatment team will be to work with the team, child and family to create an environment in which change can occur. An effective working alliance is made up of four (4) key components. These are:

- Guiding Principles –The Department of Health and Human Services (DHHS), Children's Behavioral Health Services (CBHS) Resource Guide Mission and the mission of your school/agency will guide your work.

- Rules – DHHS established licensing requirements, regulations and legal mandates that you must follow in your work as a SB-BHP.

- Responsibilities – Your school/agency has policies and procedures that you will be expected to follow. You will also have a job description that outlines the function of your job.

- You – Your life experiences, beliefs and values combined with your talents, strengths, education and training are the tools you will use in your work as a SB-BHP. You will draw on these all of these as you help the child learn and practice new skills.

GUIDING PRINCIPLES

A mission, vision and set of values are ideas that guide institutions, businesses, agencies and individuals as they carry out their work. Your school/agency also has a mission statement. A clear understanding of these missions will help guide you in your day-to-day work with the child.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)

MISSION STATEMENT

Provide integrated health and human services to the people of Maine to assist individuals in meeting their needs, while respecting the rights and preferences of the individual and family, within available resources. The statutory philosophy and intent of the department continues to be to:

- Treat consumers with respect and dignity
- Deliver services that are individualized, family-centered, easily accessible, preventive, independence-oriented, interdisciplinary, collaborative, evidence-based and consistent with best practices.
- Value and support department staff as the critical connection to the consumer.
- Engage staff, stakeholders, providers and customers in a collaborative partnership that continuously seeks excellence in service design and delivery.
- Balance centralized accountability with regional flexibility.
- Align systems, actions, and values toward a common vision.

VALUES

In support of our Vision, we in the Department value:
CHOICE People have opportunities to make informed choices and get accessible, cost effective, individually tailored supports within their community.

ACCESS People have access to jobs, education, healthcare, housing, social, spiritual and recreational opportunities.

DIGNITY People are treated with dignity and respect, and their rights are safeguarded by all who provide services to them.

QUALITY People determine the quality of their supports based on the outcomes they experience.

PREVENTION & EARLY INTERVENTION Our emphasis on prevention and early intervention will help minimize the effects of illness and disability on people's everyday lives.

CHILDREN'S BEHAVIORAL HEALTH SERVICES (CBHS)
RESOURCE GUIDE MISSION STATEMENT

MISSION STATEMENT

Children's Behavioral Health Services provides leadership in the development of a comprehensive system of care that ensures that each child develops to their fullest capacity. The system of care strengthens the capacity of families, promotes natural helping networks and develops community resources to meet the behavioral, developmental, and treatment needs of children.

YOUR MISSION STATEMENT

A clear vision, mission, and set of values are an anchor for solving the day-to-day issues as well as the larger issues that can occur as individuals carry out their work. The mission statements of DHHS, CBHS and your school/agency will guide your work as a SB-BHP. For example, the CBHS mission helps you focus on the child's strengths and accomplishments and to have clear measuring progress. The CBHS Resources Guide Mission helps to focus you on ensuring the child develops to her/his fullest capacity and on the use of natural support networks.

You may also want to develop your own mission statement and define the set of values that you will bring to your work. Situations will arise during your work with a child where you will be expected to make a decision and take a decisive action. A clear mission statement can provide you with guidance during your decision making process.

1. What is your school/agency's mission statement?_____

Take a minute to think about your beliefs, values and vision for your work as a SB-BHP. How do you see yourself bringing them into your work? Create a mission statement for your work as a SB-BHP. Some of the things that you might want to consider including in a mission statement are:

- A belief that people usually try to do the right thing
- The value of honesty
- A vision of being a positive role-model and looking for teaching opportunity

2. Using 25 words or less, write a mission statement that will guide your work as a SB-BHP. _____

3. How would you show a child and family that you hold the values of **CHOICE** and **QUALITY**? _____

Competency

B The participant will demonstrate understanding of SB-BHP roles, responsibilities and legal and regulatory requirements including mandatory reporting of abuse and neglect. (Level 1)

RULES

The rules that you are expected to follow as you perform the functions of a SB-BHP have been established by DHHS, including licensing, regulations and legal mandates. Like the Guiding Principles, a clear understanding of these rules will help you meet the day-to-day responsibilities of a SB-BHP.

LEGAL RIGHTS

DHHS – CBHS has developed a set of rights to protect children who receive mental health treatment. These rights are in *Rights of Recipients of Mental Health Services Who are Children in Need of Treatment.* Part A – Rules of General Applicability and Part C – Rights in Outpatient Settings apply to you. You are responsible for protecting the child's rights. Your school/agency is required to give you a copy of these rights and ensure that you read and understand them. Part B – discusses Rights in Inpatient and Residential settings. Briefly, Rights in Part A and C are:

Rules of General Applicability

- Basic Rights
  - Same human, civil and legal rights accorded all minor citizens
  - Human psychological and physical environment within the program
  - Treated with courtesy and dignity
  - Respect for individuality
  - Right to privacy
  - Freedom of religion
  - Protection from discrimination
- Least Restrictive Appropriate Treatment
- Notification of Rights
- Assistance in the Protection of Rights
- Right to Due Process with Regard to Grievances and Complaints
- Confidentiality and Access to Records
- Fair Compensation for Work
- Protection During Experimentation and Research
- Individualized Support Plans

Rights in Outpatient Settings

- Individualized Treatment Plan
- Informed Consent to Treatment
- Freedom from Seclusion and Restraint

These rights also apply to children receiving services under MaineCare Section 28 RCS and can be found in statutes for persons receiving services for intellectual disabilities.

Confidentiality

The family has the right to privacy. Children's Behavioral Health Services issues the "Rights of Recipients of Mental Health Services Who Are Children In Need of Treatment". In Rules of General Applicability Section III Basic Rights and Section IX, *Confidentiality of and Access to Mental Health Records* outlines the child's and family's right to privacy and confidentiality. In addition to these rights, your agency/school will have their own policies for maintaining confidentiality.

HIPAA*

The *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

- Gives patients control over the use of their private health information (PHI)
- Defines boundaries for the use/disclosure of health records by covered entities
- Establishes national-level standards that healthcare providers must comply with
- Helps to limit the use of PHI and minimizes chances of its inappropriate disclosure
- Strictly investigates compliance-related issues and holds violators accountable with civil or criminal penalties for violating the privacy of an individual PHI
- Supports the cause of disclosing PHI without individual consent for individual healthcare needs, public benefit and national interests

Examples of information protected by HIPAA include:

- Names
- Likenesses/Images
- Medical Information (* http://www.hhs. gov/ocr/privacy)

FERPA *

Family Educational Rights and Privacy Act (FERPA) gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level. Students to whom the rights have transferred are "eligible students. "

- Parents or eligible students have the right to inspect and review the student's education records maintained by the school. Schools are not required to provide copies of records unless, for reasons such as great distance, it is impossible for parents or eligible students to review the records. Schools may charge a fee for copies.
- Parents or eligible students have the right to request that a school correct records which they believe to be inaccurate or misleading. If the school decides not to amend the record, the parent or eligible student then has the right to a formal hearing. After the hearing, if the school still decides not to amend the record, the parent or eligible student has the right to place a statement with the record setting forth his or her view about the contested information.
- Generally, schools must have written permission from the parent or eligible student in order to release any information from a student's education record. However, FERPA allows schools to disclose those records, without consent, to the following parties or under the following conditions (34 CFR § 99. 31):
    - School officials with legitimate educational interest;
    - Other schools to which a student is transferring;
    - Specified officials for audit or evaluation purposes;
    - Appropriate parties in connection with financial aid to a student;
    - Organizations conducting certain studies for or on behalf of the school;
    - Accrediting organizations;
    - To comply with a judicial order or lawfully issued subpoena;
    - Appropriate officials in cases of health and safety emergencies; and
    - State and local authorities, within a juvenile justice system, pursuant to specific State law.

Schools may disclose, without consent, "directory" information such as a student's name, address, telephone number, date and place of birth, honors and awards, and dates of attendance. However, schools must tell parents and eligible students about directory information and allow parents and eligible students a reasonable amount of time to request that the school not disclose directory information about them. Schools must notify parents and eligible students annually of their rights under

FERPA. The actual means of notification (special letter, inclusion in a PTA bulletin, student handbook, or newspaper article) is left to the discretion of each school. (* Taken from http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index. html)

As a SB-SB-BHP you will be required to follow both FERPA and HIPAA guidelines, and it is important for you to have a thorough understanding of each Act and how it applies to your work.

MANDATORY REPORTING

DHHS has the authority to enforce Title 22 – Chapter 1071: Child and Family Services and Child Protection Act. The section, Subchapter II – Reporting of Abuse or Neglect defines the legal responsibilities of individuals who, while acting in a professional capacity, suspect abuse or neglect of a child. This applies to the SB-BHP. You have the legal responsibilities to report suspected abuse and neglect to DHHS. The SB-BHP is a Mandated Reporter; this means:

"When, acting in a professional capacity, an adult, who is a … mental health professional … knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected, that person shall immediately report, or cause a report to be made, to the department".

"Whenever a person is required to report in a capacity as a member of the staff of a medical, public or private institution, agency or facility, that person shall immediately notify either the person in charge of the facility, or a designated agent, who shall then cause a report to be made. The staff may also make a report directly to the Department".
"Any person may make a report if that person knows or has reasonable cause to suspect that a child has been, or is likely to be, abused or neglected. "

"When, while acting in a professional capacity, any person required to report under this section knows or has reasonable cause to suspect that a child has been abused or neglected by a person not responsible for the child, the person shall immediately report or cause a report to be made to the appropriate district attorney's office".

Immunity from Liability
A person … participating in good faith in reporting under this subchapter … is immune from any criminal or civil liability for the act of reporting …

Abuse or Neglect

Abuse or neglect means a threat to a child's health or welfare by physical, mental, or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or a lack of protection from these, by a person responsible for the child.

DOCUMENTATION

Documentation is an important responsibility of the SB-BHP. If you suspect abuse or neglect you must document all the things you observed that led you to suspect abuse or neglect. These should be the facts; what you saw or heard. You should avoid stating your impressions or opinions.

SUPERVISION

The reporting of abuse or neglect to DHHS can be very stressful. If you suspect abuse or neglect you should first contact your supervisor to discuss your concerns. Your supervisor will help you follow the school/agency's policy and procedure and together you and your supervisor will decide on the best approach for handling the reporting of the abuse to the DHHS.

If your supervisor disagrees with you and thinks there is no reason to suspect abuse or neglect, but you suspect there is abuse or neglect occurring, you are still responsible for reporting it or causing a report to be made. If you find yourself in this situation, you should identify those next in the chain of command and seek his/her advice. In the school setting, those would include the guidance counselor, assistant principal, principal, special education director, superintendent. You work through your school/agency's hierarchy before contacting DHHS.

Remember, your role is not to investigate the situation. It is your responsibility to contact your supervisor, document the facts the caused you to suspect abuse or neglect, and report or cause a report to be made. Together with the support of the team, your supervisor can set in motion a process of getting help and being a support to the child.

4. What is your school/agency's policy for reporting suspected abuse or neglect?

_____

_____

_____

_____

IDENTIFICATION

"Reasonable Cause to Believe"

The SB-BHP, schoolteachers and other school personnel are among the most effective advocates for children. These people may, in fact, be the only responsible adult in a particular child's life. Because of the special relationship between the SB-BHP, or teacher, and a child, it is essential that teachers be able to respond to the child who needs help.

The reporting laws specify that school personnel who have "reasonable cause to believe" that a child is being abused or neglected must report that suspicion to the Department of Human Services – Child Protective Services or cause a report to be made.

Identifying the sexually abused child is often difficult and undercut by uncertainty. The Committee for Children has provided training in prevention of child sexual abuse to thousands of school personnel since 1981. During this time, many teachers have contributed to our understanding of the boundaries of "reasonable cause to believe". Some of their recommendations follow:

- Resolve doubt in favor of the child.
- Discuss your observations and concerns privately with another staff person who is familiar with the child.
- Seek out and rely on your support system at school.
- Trust your instincts, your "gut" feelings.
- Remember, you do not have to prove that sexual abuse is occurring; reporting is a request for an investigation into a suspected case of abuse.
- Call Child Protective Services or a sexual assault center and request advice in determining "reasonable cause".
- Understand the importance of early case finding.
- Remember that an educator who reports is on firm legal ground.
- Incorporate a child sexual abuse prevention curriculum into the health curriculum
- Let the children in your class know that they can talk to you, a counselor, or a nurse about personal safety problems.
- If you sense a child is trying with difficulty to talk with you, sit down with a simple project – such as crayons or a puzzle – and let the child know you will believe and help her/him with any problem.
- Listen to the child.
- Be direct; if you have a trusting relationship with the child, ask gently, but directly, if the child is having a problem with which s/he needs help.
- Avoid asking probing questions.
- Believe the child who discloses; tell that child s/he has done the right thing by telling you; assure the child that s/he is not in trouble.
- Don't promise not to tell anyone else.
- Tell the child exactly what to expect; if you don't know, say so, but let the child know s/he can expect to be supported and helped by you.
- Respect the child's privacy by not discussing the situation out of school.
- If you are concerned about an administrator not making a report, call yourself; you could still be liable for failure to report.

** Adapted from material reprinted courtesy of the Charlotte White Center in Bangor, Maine (up to page 37)

Behavioral Indicators

Identifying the sexually abused child is often difficult. In general, few children speak directly about sexual abuse. Unlike physical abuse, sexual abuse may not present readily visible indicators, especially in a school setting.

The following list of behavioral indicators is offered with a gentle caution against over-zealous case identification. While no single indicator is an absolute indicator of sexual abuse, several common behaviors have been noted in the literature and corroborated by teachers through the teacher-training program of the Committee for Children. The following behaviors do not necessarily indicate sexual abuse, but can alert school personnel to a serious problem.

- Unusual interest in and/or knowledge of sexual acts and language.
- Knowledge of sexual acts, language inappropriate to the child's age or developmental level.
- The child may focus on sexual matters to the exclusion of most other activities or interests.
- Seductive behavior with classmates, teachers, other adults.
- Acting out sexual behavior; child may seem to equate affection with sex.
- Excessive masturbatory behavior.
- Attempts to touch the genitals of other children, adults, animals.
- Wearing many layers of clothing, regardless of weather.
- Inappropriate dress, such as tight and/or revealing clothing.
- Continual avoidance of bathrooms; some abuse within homes takes place in bathrooms, and a child can come to associate any bathroom with sexual abuse.
- Reluctance to go to a particular place or to be with a particular person.
- Reluctance to go home and/or constant early arrival at school.
- Excessive clinging, fear of being left alone.
- Frequent absence and/or constant late arrival to school, especially if the notes are always written by the same person.
- Sudden school problems; a marked decline in interest in school.
- An abrupt change in behavior or personality.
- An abrupt change in behavior in response to personal safety issues.
- Aggression, anger directed everywhere.
- Anxiety, irritability, constant inattentiveness.
- Regression, frequent withdrawal into fantasy.
- Over compliance, extreme docility.
- Compulsive behaviors, e. g. , hoarding, constant washing.
- Appearing to have overwhelming responsibilities.
- Suicidal threats or gestures; causing deliberate harm to her/himself.
- Use of alcohol and/or other drugs.
- Drastic change in appetite.
- Sleep disturbances, e. g. , bed wetting, nightmares, insomnia, falling asleep in class.
- Running away from home or attempting to run away.
- Denial of a problem with a marked lack of expression.
- Lack of affect, extreme absence of expressiveness.

- Depression, excessive crying.
- Low self esteem.
- Lack of friends, poor relationships with peers.
- Reluctance to undress for P. E. , continual avoidance of P. E. class.
- Indirect hints, allusions to problems at home, fishing for attention.

Physical Indicators

Although school personnel are less likely to observe physical indications of sexual abuse, there are symptoms to which school personnel should be aware:

- Venereal disease in a child of any age
- Pregnancy at 11 or 12, especially with no history of peer socialization
- Evidence of physical trauma or bleeding to the oral, genital or anal areas
- Complaints of pain or itching in those areas
- Difficulty in walking or sitting
- Unusual or offensive odors
- Torn or stained clothing
- Extreme passivity during a pelvic exam

Family Indicators

Family indicators might underscore concern regarding abuse. Possible indicators include:

- Extreme paternal dominance, restrictiveness, and/or over protectiveness
- Family isolated from the community and support systems
- Marked role reversal between mother and child
- History of sexual abuse for either parent
- Substance abuse by either parent or by other children in the home
- Other types of violence in the home
- Absent spouse (due to chronic illness, depression, divorce or separation)
- Severe overcrowding
- Complaints about a “seductive” child
- Extreme objection to implementation of child sexual abuse curriculum

Risk Assessment Inventory

How does each child present "self" (behaviorally and emotionally)?

- Age inappropriate behaviors
- Developmental delays
- Non-verbal/reticent
- Intellectual disability
- Immaturity
- Non-responsive/non-communicative/flat affect
- Aggressive/pugnacious/hostile
- Destructive
- Self-destructive
- Shy
- Problem making/keeping friends
- Fearful
- Multiple, pervasive fears of normal activities and things
- Anxious/tense
- Preoccupied with sex
- Hyperactive
- Flirtatious
- Promiscuous
- Isolated/alone
- Thoughts/threat of suicide
- Self-blaming
- Problem relating to adults
- Problem relating to peers
- Problem making eye contact
- Displays of bizarre behaviors/emotions
- Use/abuse of drugs/alcohol
- Psychosomatic illnesses/hypochondria
- Excessive attention seeking
- Exhibits habit disorders
- Poor impulse control
- Displayed/threatens cruelty toward others/animals
- Psychotic episodes, loss of reality, delusional, experiencing hallucinations
- Engaged in criminal activity/delinquency
- Poor academic performance
- Defiant/rebellious
- Withdrawn
- Depression
- Run away
- Overly compliant/submissive
- Neurotic
- Precocious sexual activity
- Guilt ridden
- Poor self-concept and poor self-esteem
- Self mutilating
- Serious mood swings
- Overly dependant
- Pseudo maturity
- Mistrusts/suspicious of parent/caretaker
- Avoids interaction with parent/caretaker
- Non-accepting of parent/caretaker
- Feels responsible for care of parent/caretaker/siblings
- No display of affection towards parent/caretaker/siblings
- Excessive fantasy for age
- Short attention span
- Sleep disturbances/eating disorders
- No sense of personal safety
- Non-accepting of parent/caretaker
- Excessive worry/anxious
- Hyper-vigilant
- Fire setting
- Depression

Disclosure

Children may disclose sexual abuse in a variety of ways. They may come to you in private and tell you directly and specifically what is going on; unfortunately, this is one of the least common ways for children to disclose. More common ways include:

- **Indirect hints**. e. g. "My brother wouldn't let me sleep last night. " "Mr. Jones wears funny underwear. " "Daddy's trying to poison me. " "My babysitter keeps bothering me. " A child may talk in these terms because s/he hasn't learned more specific vocabulary, feels too ashamed or embarrassed to talk more directly, has promised not to tell, or for a combination of these reasons. Contact your supervisor and tell him/her exactly what the child said. Bear in mind that in order to make a report you do not need to know exactly what form the abuse has taken.
- **Disguised disclosure**. "I know someone who is being touched in a bad way. " "What would happen if a girl told her mother she was being molested but her mother didn't believe her?" Here the child might be talking about a friend or sibling, but he/she is just as likely to be talking about her/himself. Contact your supervisor and tell him/her exactly what the child said. Your supervisor may suggest that you follow up with the child and ask him/her to be more specific.
- **Disclosure with strings attached**. "I have a problem but if I tell you about it you have to promise not to tell anyone else. " Most children are all too aware that some negative consequences will result if they break the secret of abuse; often the offender uses the threat of these consequences to force the child to remain silent. Let the child know you want to help her/him, and that the law requires you to make a report if the child discloses abuse; just as the molestation itself is against the law, so too is it for you not to report. Assure the child you will respect his/her need for confidentiality by not discussing the abuse with anyone other than those directly involved with the legal process, who might include your supervisor and/or the Child Protective Services Investigator.
- It is not your responsibility to investigate what a child says. It is your responsibility to report suspected abuse or neglect. It is your responsibility to contact your supervisor, objectively document what you suspect, report or cause a report of the abuse or neglect to be made, with the support of your supervisor, set in motion the process of getting help for the child, and finally, to be supportive of the child.

Here are some suggestions for responding to disclosure:

- Find a private place to talk with the child
- Do not panic or express shock.
- Don’t promise not to tell.
- Express your belief that the child is telling you the truth.
- Listen carefully to the child.
- Avoid asking probing questions.
- Use the child’s vocabulary.
- Reassure the child that it is good to tell.
- Reassure the child that it is not her/his fault, that s/he is not bad.
- Determine the child’s immediate need for safety.
- Let the child know that you will do your best to protect and support him/her.
- Let the child know what you will do.
- Report to your supervisor.

Normal Childhood Sexual Development

A. Infancy (birth to 2 years)

1. Caregiver response to infant teaches trust, security, love; having basic needs met consistently creates hopeful attitude for the future
2. Communication through touch, ease or tension in handling, eye contact, tone of voice, are earliest sensual messages
3. Need for oral satisfaction; sucking needs met by feeding, but pacifiers and other substitutes may be sought by infant
4. Sexual response system begins working in the uterus and at birth, males with erection of penis, females with lubrication of vagina
5. Sex role conditioning begins (boy and girl babies treated differently)
6. Family encourages male or female gender identity
7. Awareness of anatomy differences
8. Exploration of own body
9. Family builds or discourages self esteem

B. Toddler (1 ½ to 3 years)

1. Child becomes aware of non-genital gender differences, personal gender identity becomes fixed
2. Toilet learning brings beginning of separation and awareness of self
3. Language skills provide potential to begin to acquire vocabulary for sexual parts and processes
4. Increasing independence in all areas, needs specific praise for accomplishments to enhance self esteem
5. Deliberate genital touching, caregiver response can bring acceptance of body or shame
6. Concerns about anatomy differences may be verbalized, questions begin

C. Early Childhood (3-5 years)

1. Active curiosity about reproduction (where do I come from?) and relation to family, community
2. Gender identity affirmed; play often takes on different gender roles
3. Deliberate self stimulation (not goal oriented as in adult behavior)
4. May participate in sexual play with children of either gender
5. May have hostile feelings toward children of other sex, seeks closeness with same sex friends
6. Child may develop need for privacy, modesty
7. Continued need for positive, nurturing touch

D. Late childhood (5-9 years)

1. Curiosity about sexual function and differences usually resolved or hidden; less open questioning
2. Child absorbs messages about sexuality from wider world
3. Deliberate gender segregation in play
4. Active interest in information and logical answers
5. Sexual exploration by both same and other gender friends common (not necessarily a sign of orientation)
6. Esteem enhanced by work, chores, success in industry
7. Onset of prepubescent surge in hormones, growth of internal and external sexual organs

E. Early adolescence (9-13 years)

1. Beginning of reproductive system functioning; males ejaculation by 14, females menstruation by sixteen (16)
2. Increasing dependence on peer group
3. Increasingly intense romantic attachments, experimental crushes
4. Physical changes often preoccupy child (am I normal?)
5. Changing relationships with family, friends, primary concern
6. Differences in male and female approaches to self stimulation
7. Widest variety in growth and development
8. Child may feel awkward, clumsy, mood changes common

F. Adolescence (14-20)

1. Absorption in questions regarding self and identity
2. Youth may experiment with various roles
3. Body changes of puberty continue (male growth spurt by 15, females by 12)
4. Strong needs for independence and guidance conflict
5. Sexual feelings intensify, experimentation with behavior
6. Awareness of sexual orientation clearer
7. Self stimulation goal oriented
8. Reproductive ability makes decision making re: sexuality serious with life change repercussions
9. Changing from concrete to abstract thinking (youth may identify with social, religious, groups)
10. Desire for clear gender differences change to awareness of different values
11. Sex role expectations may be questioned in later adolescence
12. Higher capacity for social/moral judgments

13. Peer pressure and double standards for males and females influence decision on behavior
14. Increased capacity for intimacy.

RESPONSIBILITIES

The DHHS Office of MaineCare Services which administers MaineCare, has established regulations for the delivery of Children's Behavioral Health Services. Your school/agency will give you a job description that will include the regulations that apply to your work as a SB-BHP. Your school/agency will also have policies and procedures that will outline a range of responsibilities such as writing incident/accident reports, supervision, documenting the child's progress, reporting abuse or neglect, as well as sick and vacation time.

THE SCHOOL-BASED BEHAVIORAL HEALTH PROFESSIONAL ROLE

The role of the SB-BHP will vary depending upon the MaineCare Section that is reimbursing the service.

- The SB-BHP's work under Section 65 Day Treatment defines the Children's Behavioral Health Day Treatment as a covered service is a specific service determined to be medically necessary by Qualified Staff licensed to make such a determination and subsequently specified in the Individual treatment plan (ITP) and for which payment to a provider is permitted under the rules of this Section. This Qualified Staff must assume clinical responsibility for medical necessity and the ITP development. Children's Behavioral Health Day Treatment Services described below are covered when (1) provided in an appropriate setting as specified in the ITP, (2) supervised by an appropriate professional as specified in the ITP, (3) performed by a qualified provider, and (4) billed by that provider. Behavioral Health Day Treatment Services must be delivered in conjunction with an educational program in a School.

  Behavioral Health Day Treatment Services are structured therapeutic services designed to improve a member's functioning in daily living and community living. Programs may include a mixture of individual, group, and activities therapy, and also include therapeutic treatment oriented toward developing a child's emotional and physical capability in area of interpersonal functioning. This may include behavioral strategies and interventions. Services will be provided as prescribed in the ITP.

  Involvement of the member's family will occur in treatment planning and provision. Behavioral Health Day Treatment Services may be provided in conjunction with a residential treatment program. Services are provided

based on time designated in the ITP but may not exceed six (6) hours per day, Monday through Friday, up to five days per week. Medically Necessary Services must be identified in the ITP.

- The SB-BHP's work as outlined under Section 28 RCS requires that providers delivering services in the home and community have a contract with DHHS-CBHS. Treatment Services for Children with Cognitive Impairments and Functional Limitations are medically necessary treatment services for members under the age of twenty one (21). Treatment services are designed to retain or improve functional abilities which have been negatively impacted by the effects of cognitive or functional impairment and are focused on behavior modification and management, social development, and acquisition and retention of developmentally appropriate skills. Services include problem solving activities in order to help the member develop and maintain skills and abilities necessary to manage his or her behavioral health treatment needs, learning the social skills and behaviors necessary to live with and interact with other community members and independently, and to build or maintain satisfactory relationships with peers or adults, learning the skills that will improve a member's self awareness, environmental awareness, social appropriateness and support social integration, and learning awareness of and appropriate use of community services and resources.

  Specialized Services for Children with Cognitive Impairments and Functional Limitations are medically necessary, evidence based treatment services for members under the age of twenty one (21), that utilize behavioral interventions designed to improve socially significant behaviors and developmentally appropriate skills to a measurable degree. Services include problem solving activities in order to help the member develop and maintain skills and abilities necessary to manage his or her behavioral health treatment needs, learning the social skills and behaviors necessary to live with and interact with other community members and independently, and to build or maintain satisfactory relationships with peers or adults, learning the skills that will improve a member's self awareness, environmental awareness, social appropriateness and support social integration, and learning awareness of and appropriate use of community services and resources.

Competency

C The participant will demonstrate an understanding of disabilities, including the effects of the disabilities on the child and family, and community attitudes towards children with disabilities and their families. (Level 1)

STIGMATIZATION

Merriam – Webster Dictionary defines Stigma as "a mark of shame or discredit or an identifying mark or characteristic". Stigmatization is defined as "to characterize or brand as disgraceful or shameful.

Often when we meet a new person or find ourselves in a new situation, you will make assumptions about the person or situation. When we make these assumptions, we are trying to get comfortable with the new situation or person. This is a normal strategy for making sense of a new situation or people who are different from us. Usually, we check out assumptions to see if they are in fact correct. If/and when we notice that our assumptions are incorrect, we change them so that we are responding appropriately to the situation or the person.

We tend to create problems for ourselves when we respond to a situation based on our assumptions. We can treat people unfairly when we let our assumptions stand as facts. When we make an assumption about a person, label them, and then treat them according to the label we placed on them, we are stigmatizing them. For example, when we say, "Katie is ODD" (Oppositional Defiant Disorder) we are implying that Katie is only ODD; our perception of her is limited to seeing her as only being her diagnosis. We are only seeing one aspect of the person. When we say, "Katie is a child with ODD" we are implying that the ODD is only one part of who Katie is; our perception is open to seeing other parts of who she is; perhaps she is good at baseball and likes to sing. We can easily lose sight of the whole person when we refer to them as the diagnosis. It is important to see the diagnosis as only one aspect of the person and to see all the unique strengths, interests, talents and traits of each person.

A family that has a child with a disability faces many challenges. Many of them have to do with the unique challenges that are specifically related to the disability. Other challenges have to do with how the disability is perceived by the child, family and community. The child may need support in coping with the stigma

attached to mental illness or intellectual disability. It is extremely important to understand the subtle and not so subtle ways in which people with disabilities are stigmatized. As a SB-BHP, you will need to become sensitive to the many ways in which assumptions are made about children who have a disability and their families.

7. Compare and contrast the following statements:

Harry is autistic. _____

Harry is a child with autism. _____

8. What are some of the assumptions that are made about children who have disabilities and their families?_____

Competency

E The participant will demonstrate the ability to solve problems related to the delivery of home-based behavioral health services. (Level 2)

PROBLEM SOLVING

Your work as a SB-BHP will involve a great deal of problem solving. You will need to become an effective problem solver. When you are engaged in the problem solving process you are doing two (2) important things. The first is solving a problem the second is role-modeling problem solving for the child you are working with.

Various writers and trainers have developed procedures that assist individuals and groups in solving problems cooperatively. These procedures range from five to seven steps, but all follow the same pattern and include the same components. In general, the purpose of the various problem-solving strategies is to strengthen communication and enhance the ability of individuals working together.

The following is a combination of several different problem-solving approaches. Michael Mitchell, LCSW developed this method.

P – Problem

O – Options

A – Action

R – Results

You will need to know how to effectively solve problems and also how to teach problem solving to the child and family. The effective use of the POAR problem solving strategy will enable you to gain a better understanding of the child and the interventions that are most effective.

The **POAR** problem-solving method has four (4) steps.

P Step 1: **– Problem** – This is the critical first step that involves bringing the problem into the light of day. How the problem is defined will affect the rest of the process. This step recognizes/identifies the **immediate problem** and avoids being sidetracked by the larger issues. It describes what is happening in the moment,

what the child is actually doing and feeling or what is actually happening between two people and how they are feeling. The immediate problem is defined objectively. The immediate problem is an objective and accurate statement about the facts of the situation.

For example: Billy and Suzy are playing a game. Suzy wins the game, and Billy seems mad. Billy hits Suzy. The immediate problem is that Billy hit Suzy.

An error that can occur when defining the problem is getting sidetracked by the larger issues. There are often many layers that can affect the problem; attempting to address underlying issues while emotions are running high can cause the situation to escalate. Accurately seeing and hearing what is happening in the moment is vital to effective problem solving. Keeping the attention on the facts can help each person involved in the problem feel seen and heard.

In our example, the larger issue, which is not dealt with in the moment, may be that Billy is jealous of Suzy or that he feels inadequate because he lost the game or it is his inability to control his anger. These are guesses about what might be causing Billy to hit Suzy. The larger issue cannot be dealt with in the moment and trying to focus on it could cause the situation to escalate. Keep the focus on the immediate problem. What is happening? What can help bring about a quick and effective solution?

Oftentimes when a problem is occurring, the people involved in it have very strong feelings. Sometimes in your work as a SB-BHP, you will have strong feelings about what is occurring. Paying attention to the facts helps you keep control over your emotions. It also helps you to keep your personal views and beliefs from clouding the issue. Depersonalizing the problem will help you objectively describe the behaviors associated with the problem and can decrease the likelihood of making judgments about the people involved. Assigning blame, making judgments or focusing on the person and not the problem can cause the situation to escalate.

There may be situations in which you will be able to talk with everyone involved and together define the problem. In other situations, you will need to define the problem on your own. Whether defining the problem with the people involved or on your own, the problem should be clearly stated so that everyone involved understands. It is often useful to recognize how each person might be feeling. For example, identifying that Billy feels mad and Suzy feels hurt.

Something that you might say in this situation is: "Billy and Suzy, it looks like we have a problem. Billy it seems like you are mad and hit Suzy in the arm and Suzy, it seems like you feel hurt. "

O Step 2: **– Options** – This is the creative aspect of problem solving. The aim is to develop a variety of solutions to the problem. In some situations, you will be able to engage everyone in coming up with solutions. When this happens, you will engage everyone in a brainstorming process to generate ideas for solving the problem. You will want to frame the brainstorming process by stating that the solutions need to be consistent with the ITP. This process should be done in a supportive and non-judgmental way. The aim is to come up with as many options as possible for solving the problem.

In other situations you will be formulating your own solutions. The solution is intended to respond to the immediate problem. Again, the intent is to generate as many solutions as possible that will address the immediate problem and will be consistent with the child's ITP.

Using our example some of the options might be to:

- Direct Billy to stop hitting Suzy.
- Invite Billy to play another game thus distracting him.
- Engage Billy in a skill building activity such as a relaxation exercise.
- Identify Billy and Suzy's feelings.
- Support a conversation between Billy and Suzy.
- Coach Billy to manage his anger.
- Ask Suzy to go into another room.

Often, similar problems will occur. It will be important to keep in mind that option or solutions are 'time dependent'. This means that the option or solution you used the last time to solve the problem may not necessarily solve the same problem when it occurs again. Each time a problem occurs, no matter how familiar it is, you should be open to exploring new options. You should approach each problem as though you were solving it for the first time.

A Step 3: **– Action** – This is the implementation phase. There are two parts to the implementation phase. The first is 'testing the options' by asking yourself some questions that will help you decide on the best option. The second is putting the option into action.

In situations when everyone has participated in defining the problem and created a list of options, they will pick the one that seems best and implement it. When you are acting alone, you will implement the option that seems most appropriate. It is

important to keep in mind that the option that is implemented must be consistent with the ITP.

When choosing an option you may want to ask yourself the following:

- What are the risks and benefits?
- Is there any reason why this option will not work?
- Will the option be hard to do?
- Will it be hard to follow through with the option?
- Is the option consistent with my school/agency's policies and procedures?
- Is the option consistent with the ITP?
- Is the option fair to everyone involved?

Sometimes, when you are 'testing the options', a new option will arise or an original option will be improved upon. It is important to remain flexible. Pay careful attention to 'testing the options' as it will help you pick the one that seems to be the best.

It is important to make sure that everyone involved agrees on the option picked. When you are acting alone, you will pick the options that seem the most appropriate.

Once you select an option, it is time to put it into action. You will make a plan with everyone involved about how the plan will be carried out. You will want to make sure that everyone involved understands what was decided upon and what each person will do. Each person's responsibility and the time frame for completing it should be clearly stated and understood by everyone involved. When you are going through the process on your own, you will want to be clear about all the steps that you will need to take in order to carry out the option. Sometimes you may use more than one option to solve the problem. As you decide on an option to use you should have an idea about how you will measure the effectiveness of your action. You will want to have an idea about what a successful outcome will look like.

You will be in situations that require you to respond immediately. Often these situations will be complex and multi-faceted and you will be moving quickly through the problem solving steps. Your ability to attend to the immediate observable problem and not be side-tracked by the larger issues will impact the options you come up with to solve the problem, the action you take and ultimately your effectiveness as a problem solver.

In our example, two options might be used. The first is that Billy is directed to stop hitting Suzy and the second is that Billy and Suzy are asked to come up with some

ideas about how they might play together.

OR

The first action is to ask Suzy to go to another room and the second action is to coach Billy on managing his anger.

R Step 4: **– Results** – This is the evaluation step. Reflecting on the effectiveness of the action as well as the responses of everyone involved will help you to gain additional information about the child and family and effective methods for working together. It can be useful to discuss the results with the child and family and in supervision.

When you look back on a problem solving process you will want to look at how you functioned and the effectiveness of the process.

Some of the questions you might ask yourself are:

- What did I learn about my reaction?
- Did I stay calm?
- If I did not stay calm, what caused me to feel anxious?
- Did I focus on the immediate problem; the behavior as it occurred?
- Did I focus on the issue that led up to the problem?
- Did I focus on the affect of the behavior?
- How did my definition of the problem affect the outcome?

Some of the questions you might ask yourself about the process are:

- What worked?
- What did not work?
- Was there something that could have prevented the problem from occurring?
- How did the people involved respond?

Some of the questions you might ask yourself about the child are:

- Is there a pattern in the child's behavior?
- Was there a change in the child's ability to deal with the problem?
- Was the change an improvement or regression?
- What need was the child trying to meet?
- Did the option address the child's need?

Thoughtful reflection on how you solved the problem will help you learn more about yourself, the child and effective ways to solve problems. It is good practice to review how you handle difficult situations in supervision. You will want to use

your supervisor to help you identify your strength and what you can do to improve your problem solving skills.

10. Problem Solving Exercise: Apply the Problem Solving Method to the following scenario.

- What is the immediate problem?
- What are some of the options you might use to solve the problem?
- Identify two (2) questions you would ask yourself when picking an option/action.
- Identify two (2) questions you would ask yourself when you are evaluating the action you took.

Beth, a high school student that you work with in the resource room, often becomes upset when asked to do math activities. During this period she is expected to complete a pair of worksheets for her math class. As you place the worksheets on the table, Beth grabs them, rips them up and throws them onto the floor.

Competency

F The participant will demonstrate an understanding of teamwork. (Level 2**)**

TEAM

You are a member of an IEP/ITP team. The purpose of the team is to assist the child and family with identifying their goals and providing them with the support that is needed to meet them.

All treatment teams should have the parent(s) and child as the team leaders. The parent(s) are the people who have spent the most time with the child and have the most intimate knowledge about her/him. The parent(s) are the people who have tried lots of different ways to meet their challenges. The parent(s) should be setting the goals for the child. The other members on the team need to learn from the parent(s)' experience and build on them.

Other members of the team include you and your supervisor. The team may also include other individuals who are assisting the family, such as:

- Case managers
- Speech therapists
- Psychiatrists
- Natural supports such as friends or relatives

Everyone on the team brings a unique perspective on what will help the child and family meet their goals. There are four (4) things that each team member can do to support a respectful and productive team. These are:

- Working interdependently – this means understanding how each person on the team will assist the child and family.
- Freely sharing ideas and talents – this means being willing to share your thoughts and observations and doing what is needed, within the scope of your job.
- Accepting disagreement as an opportunity to discover the best thing to do – this means seeing the differences in opinions and being open to changing an opinion if it is the best thing for the situation.

- Listening – this means seeking to understand, instead of expecting to be understood.

These four (4) characteristics of a good team member can be summed up in the Team Golden Rule – each team member treats every other team member as they would like to be treated. A good way to think about team is this acronym:

T – Together
E – Everyone
A – Achieves
M – More

Title 22-CHAPTER 1071

CHILD AND FAMILY SERVICES AND CHILD PROTECTION ACT

Subchapter 1: GENERAL PROVISIONS

22 §4001. TITLE

This chapter may be cited as the "Child and Family Services and Child Protection Act. " [1979, c. 733, §18 (NEW).]

SECTION HISTORY

1979, c. 733, §18 (NEW).

22 §4002. DEFINITIONS

As used in this chapter, unless the context indicates otherwise, the following terms have the following meanings. [1979, c. 733, §18 (NEW).]

1. **Abuse or neglect.** "Abuse or neglect" means a threat to a child's health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection from these or failure to ensure compliance with school attendance requirements under Title 20-A, section 3272, subsection 2, paragraph B or section 5051-A, subsection 1, paragraph C, by a person responsible for the child.

[2007, c. 304, §10 (AMD) .]

1-A. **Abandonment.** "Abandonment" means any conduct on the part of the parent showing an intent to forego parental duties or relinquish parental claims. The intent may be evidenced by:

A. Failure, for a period of at least 6 months, to communicate meaningfully with the child; [1995, c. 481, §1 (AMD).]

B. Failure, for a period of at least 6 months, to maintain regular visitation with the child; [1995, c. 481, §1 (AMD).]

C. Failure to participate in any plan or program designed to reunite the parent with the child; [1983, c. 184, §1 (NEW).]

D. Deserting the child without affording means of identifying the child and his parent or custodian; [1983, c. 184, §1 (NEW).]

E. Failure to respond to notice of child protective proceedings; or [1983, c. 184, §1 (NEW).]

F. Any other conduct indicating an intent to forego parental duties or relinquish parental claims. [1983, c. 184, §1 (NEW).]

[1995, c. 481, §1 (AMD) .]

1-B. **Aggravating factor.** "Aggravating factor" means any of the following circumstances with regard to the parent.

A. The parent has subjected any child for whom the parent was responsible to aggravated circumstances, including,

but not limited to, the following:

(1) Rape, gross sexual misconduct, gross sexual assault, sexual abuse, incest, aggravated assault, kidnapping, promotion of prostitution, abandonment, torture, chronic abuse or any other treatment that is heinous or abhorrent to society. [2001, c. 696, §10 (AMD).]

A-1. The parent refused for 6 months to comply with treatment required in a reunification plan with regard to the child. [2001, c. 696, §11 (NEW).]

B. The parent has been convicted of any of the following crimes and the victim of the crime was a child for whom the parent was responsible or the victim was a child who was a member of a household lived in or frequented by the parent:

(1) Murder;

(2) Felony murder;

(3) Manslaughter;

(4) Aiding, conspiring or soliciting murder or manslaughter;

(5) Felony assault that results in serious bodily injury; or

(6) Any comparable crime in another jurisdiction. [1997, c. 715, Pt. B, §1 (NEW).]

C. The parental rights of the parent to a sibling have been terminated involuntarily. [1997, c. 715, Pt. B, §1 (NEW).]

D. The parent has abandoned the child. [1997, c. 715, Pt. B, §1 (NEW).]

[2001, c. 696, §§10, 11 (AMD) .]

2. **Child.** "Child" means any person who is less than 18 years of age.

[1979, c. 733, §18 (NEW) .]

3. **Child protection proceeding.** "Child protection proceeding" means a proceeding on a child protection petition under subchapter IV, a subsequent proceeding to review or modify a case disposition under section 4038, an appeal under section 4006, a proceeding on a termination petition under subchapter VI, or a proceeding on a medical treatment petition under subchapter VIII.

[1979, c. 733, §18 (NEW) .]

3-A. **Child Welfare Services Ombudsman.**

[2001, c. 439, Pt. X, §1 (RP) .]

4. **Custodial parent.** "Custodial parent" means a parent with custody.

[1979, c. 733, §18 (NEW) .]

5. **Custodian.** "Custodian" means the person who has legal custody and power over the person of a child.

[1979, c. 733, §18 (NEW) .]

5-A. **Foster parent.** "Foster parent" means a person whose home is licensed by the department as a family foster home as defined in section 8101, subsection 3 and with whom the child lives pursuant to a court order or agreement with the department.

[1997, c. 715, Pt. B, §2 (NEW) .]

6. **Jeopardy to health or welfare or jeopardy.** "Jeopardy to health or welfare" or "jeopardy" means serious abuse or neglect, as evidenced by:

A. Serious harm or threat of serious harm; [1979, c. 733, §18 (NEW).]

B. Deprivation of adequate food, clothing, shelter, supervision or care or education when the child is at least 7 years of age and has not completed grade 6; [2007, c. 304, §11 (AMD).]

B-1. Deprivation of necessary health care when the deprivation places the child in danger of serious harm; [2005, c. 373, §5 (NEW).]

C. Abandonment of the child or absence of any person responsible for the child, which creates a threat of serious harm; or [1983, c. 184, §2 (AMD).]

D. The end of voluntary placement, when the imminent return of the child to his custodian causes a threat of serious harm. [1979, c. 733, §18 (NEW).]

[2007, c. 304, §11 (AMD) .]

6-A. **Licensed mental health professional.** "Licensed mental health professional" means a psychiatrist, licensed psychologist, licensed clinical social worker or certified social worker.

[1985, c. 495, §16 (NEW) .]

7. **Parent.** "Parent" means a natural or adoptive parent, unless parental rights have been terminated.

[1979, c. 733, §18 (NEW) .]

7-A. **Permanent plan.**

[2005, c. 372, §2 (RP) .]

8. **Person.** "Person" means an individual, corporation, facility, institution or agency, public or private.

[1979, c. 733, §18 (NEW) .]

9. **Person responsible for the child.** "Person responsible for the child" means a person with responsibility for a child's health or welfare, whether in the child's home or another home or a facility which, as part of its function, provides for care of the child. It includes the child's custodian.

[1979, c. 733, §18 (NEW) .]

9-A. **Preadoptive parent.** "Preadoptive parent" means a person who has entered into a preadoption agreement with the department with respect to the child.

[1997, c. 715, Pt. B, §3 (NEW) .]

9-B. **Relative.** "Relative " means the biological or adoptive parent of the child's biological or adoptive parent, or the biological or adoptive sister, brother, aunt, uncle or cousin of the child .

[2007, c. 371, §1 (AMD) .]

9-C. **Removal of the child from home.** "Removal of the child from home" means that the department or a court has taken a child out of the home of the parent, legal guardian or custodian without the permission of the parent or legal guardian.

[1997, c. 715, Pt. B, §3 (NEW) .]

10. **Serious harm.** "Serious harm" means:

A. Serious injury; [1979, c. 733, §18 (NEW).]

B. Serious mental or emotional injury or impairment which now or in the future is likely to be evidenced by serious mental, behavioral or personality disorder, including severe anxiety, depression or withdrawal, untoward aggressive behavior, seriously delayed development or similar serious dysfunctional behavior; or [1985, c. 739, §3 (AMD).]

C. Sexual abuse or exploitation. [1979, c. 733, §18 (NEW).]

[1985, c. 739, §3 (AMD) .]

11. **Serious injury.** "Serious injury" means serious physical injury or impairment.

[1979, c. 733, §18 (NEW) .]

12. **Suspicious child death.** "Suspicious child death" means the death of a child under circumstances in which there is reasonable cause to suspect that abuse or neglect was a cause of or factor contributing to the child's death.

[2007, c. 586, §1 (NEW) .]

SECTION HISTORY

1979, c. 733, §18 (NEW). 1983, c. 184, §§1,2 (AMD). 1985, c. 495, §16 (AMD). 1985, c. 739, §§1-3 (AMD). 1987, c. 511, §A2 (AMD). 1987, c. 769, §A77 (AMD). 1995, c. 481, §1 (AMD). 1997, c. 715, §§B1-3 (AMD). 2001, c. 439, §X1 (AMD). 2001, c. 696, §§10,11 (AMD). 2005, c. 372, §2 (AMD). 2005, c. 373, §§4,5 (AMD). 2007, c. 304, §§10, 11 (AMD). 2007, c. 371, §1 (AMD). 2007, c. 586, §1 (AMD).

22 §4003. PURPOSES

Recognizing that the health and safety of children must be of paramount concern and that the right to family integrity is limited by the right of children to be protected from abuse and neglect and recognizing also that uncertainty and instability are possible in extended foster home or institutional living, it is the intent of the Legislature that this chapter: [1997, c. 715, Pt. B, §4 (AMD).]

1. **Authorization.** Authorize the department to protect and assist abused and neglected children, children in circumstances which present a substantial risk of abuse and neglect, and their families;

[1979, c. 733, §18 (NEW) .]

2. **Removal from parental custody.** Provide that children will be taken from the custody of their parents only where failure to do so would jeopardize their health or welfare;

[1979, c. 733, §18 (NEW) .]

3. **Reunification as a priority.** Give family rehabilitation and reunification priority as a means for protecting the welfare of children, but prevent needless delay for permanent plans for children when rehabilitation and reunification is not possible;

[1999, c. 731, Pt. AA, §3 (AMD) .]

3-A. **Kinship placement.** Place children who are taken from the custody of their parents with an adult relative when possible;

[2005, c. 374, §1 (NEW) .]

4. **Permanent plans for care and custody.** Promote the early establishment of permanent plans for the care and custody of children who cannot be returned to their family. It is the intent of the Legislature that the department reduce the number of children receiving assistance under the United States Social Security Act, Title IV-E, who have been in foster care more than 28 months, by 10% each year beginning with the federal fiscal year that starts on October 1, 1983; and

[1999, c. 731, Pt. AA, §4 (AMD) .]

5. **Report.** Require the department to report monthly to the joint standing committees of the Legislature having jurisdiction over appropriations and financial affairs and health and human services matters, beginning in July 2000, on the status of children served by the Bureau of Child and Family Services. The report must include, at a minimum, information on the department's caseload, the location of the children in the department's custody and the number of cases of abuse and neglect that were not opened for assessment. This information must be identified by program and funding source.

[1999, c. 731, Pt. AA, §5 (NEW) .]

SECTION HISTORY

1979, c. 733, §18 (NEW). 1981, c. 369, §9 (AMD). 1981, c. 698, §96 (AMD). 1985, c. 739, §4 (AMD). 1997, c. 715, §B4 (AMD). 1999, c. 731, §§AA3-5 (AMD). 2005, c. 374, §1 (AMD).

22 §4004. AUTHORIZATIONS

1. **General.** The department may take appropriate action, consistent with available funding, that will help prevent child abuse and neglect and achieve the goals of section 4003 and subchapter XI-A, including:

A. Developing and providing services which:

(1) Support and reinforce parental care of children;

(2) Supplement that care; and

(3) When necessary, substitute for parental care of children; [1979, c. 733, §18 (NEW).]

B. Encouraging the voluntary use of these and other services by families and children who may need them; [1979, c. 733, §18 (NEW).]

C. Cooperating and coordinating with other agencies, facilities or persons providing related services to families and children; [1993, c. 294, §1 (AMD).]

D. Establishing and maintaining a Child Protective Services Contingency Fund to provide temporary assistance to families to help them provide proper care for their children; [2007, c. 586, §2 (AMD).]

E. Establishing a child death and serious injury review panel for reviewing deaths and serious injuries to children. The panel consists of the following members: the Chief Medical Examiner, a pediatrician, a public health nurse, forensic and community mental health clinicians, law enforcement officers, departmental child welfare staff, district attorneys and criminal or civil assistant attorneys general.

The purpose of the panel is to recommend to state and local agencies methods of improving the child protection system, including modifications of statutes, rules, policies and procedures ; and [2007, c. 586, §3 (AMD).]

F. Investigating suspicious child deaths. An investigation under this paragraph is subject to and may not interfere with the authority and responsibility of the Attorney General to investigate and prosecute homicides pursuant to Title 5, section 200-A. [2007, c. 586, §4 (NEW).]

[2001, c. 11, §4 (AMD); 2007, c. 586, §§2-4 (AMD) .]

2. **Duties.** The department shall act to protect abused and neglected children and children in circumstances that present a substantial risk of abuse and neglect, to prevent further abuse and neglect, to enhance the welfare of these children and their families and to preserve family life wherever possible. The department shall:

A. Receive reports of abuse and neglect and suspicious child deaths; [2007, c. 586, §5 (AMD).]

B. Promptly investigate all abuse and neglect cases and suspicious child deaths coming to its attention or, in the case of out-of-home abuse and neglect investigations, the department shall act in accordance with subchapter 11-A; [2007, c. 586, §6 (AMD).]

C. Determine the degree of harm or threatened harm to each child in each case; [2001, c. 559, Pt. CC, §1 (AMD).]

D. [2001, c. 559, Pt. CC, §1 (RP).]

E. If, after investigation, the department does not file a petition under section 4032 but does open a case to provide services to the family to alleviate child abuse and neglect in the home, assign a caseworker, who shall:

(1) Provide information about rehabilitation and other services that may be available to assist the family; and

(2) Develop with the family a written child and family plan.

The child and family plan must identify the problems in the family and the services needed to address those problems; must describe responsibilities for completing the services, including, but not limited to, payment for services, transportation and child care services and responsibilities for seeking out and participating in services; and must state the names, addresses and telephone numbers of any relatives or family friends known to the department or parent to be available as resources to the family.

The child and family plan must be reviewed every 6 months, or sooner if requested by the family or the department; [2007, c. 586, §7 (AMD).]

F. File a petition under section 4032 if, after investigation, the department determines that a child is in immediate risk of serious harm or in jeopardy as defined in this chapter ; and [2007, c. 586, §8 (AMD).]

G. In the case of a suspicious child death, determine:

(1) Whether abuse or neglect was a cause or factor contributing to the child's death; and

(2) The degree of threatened harm to any other child for whom the person or persons responsible for the deceased child may be responsible now or in the future. [2007, c. 586, §9 (NEW).]

[2001, c. 559, Pt. CC, §1 (AMD); 2007, c. 586, §§5-9 (AMD) .]

3. **Objection of parent.** Except as specifically authorized by law, no person may take charge of a child over the objection of his parent or custodian.

[1979, c. 733, §18 (NEW) .]

SECTION HISTORY

1979, c. 733, §18 (NEW). 1987, c. 744, §§1,2 (AMD). 1991, c. 828, §§A44,45 (AMD). 1993, c. 294, §§1,2 (AMD). 2001, c. 11, §4 (AMD). 2001, c. 559, §CC1 (AMD). 2007, c. 586, §§2-9 (AMD).

22 §4004-A. VOLUNTARY AGREEMENTS

1. **Agreement authorized.** If the following conditions are met, the department and a custodian may enter into a mutual agreement in which the custodian retains custody of the child and the department agrees to provide services to the child.

A. The department finds that staying in the custodian's home would be detrimental to the welfare of the child. [1993, c. 728, §1 (NEW).]

B. The department finds that, absent a mutual agreement, the child is at risk of entering the child protection system or the juvenile justice system. [1993, c. 728, §1 (NEW).]

[1993, c. 728, §1 (NEW) .]

2. **Agreement requirements.** An agreement entered into pursuant to subsection 1 must meet the following requirements.

A. The agreement may not exceed 180 days unless, within the 180 days, the District Court has found that returning to the custodian's home would be detrimental to the welfare of the child. If the court has made that determination, the agreement may continue but must be reviewed by the court no more than 18 months after commencement of the agreement and at least every 2 years following the 18-month review. [1993, c. 728, §1 (NEW).]

B. The agreement must specify the legal status of the child and the rights and obligations of the custodian, the child, the department and any other parties to the agreement. [1993, c. 728, §1 (NEW).]

C. If the custodian is able to contribute resources to the care of the child, that contribution must be specified in the agreement. Resources include, but are not limited to, insurance coverage and disposable income. [1993, c. 728, §1 (NEW).]

D. The agreement must be approved by the commissioner or the commissioner's designee. [1993, c. 728, §1 (NEW).]

[1993, c. 728, §1 (NEW) .]

3. **Additional parties.** The Department of Corrections, the Department of Education, the Office of Substance Abuse and any other appropriate state agency may be additional parties to the agreement.

[2003, c. 2, §77 (COR) .]

4. **Section 4022 not affected.** This section does not apply to agreements entered into under section 4022.

[1993, c. 728, §1 (NEW) .]

5. **Rules.** The department may adopt rules to implement this section.

[1993, c. 728, §1 (NEW) .]

SECTION HISTORY

1993, c. 728, §1 (NEW). 1995, c. 560, §K82 (AMD). 1995, c. 560, §K83 (AFF). 2001, c. 354, §3 (AMD). RR 2003, c. 2, §77 (COR).

22 §4004-B. INFANTS BORN AFFECTED BY SUBSTANCE ABUSE OR AFTER PRENATAL EXPOSURE TO DRUGS

The department shall act to protect infants born identified as being affected by illegal substance abuse or suffering from withdrawal symptoms resulting from prenatal drug exposure, whether or not the prenatal exposure was to legal or illegal drugs, regardless of whether or not the infant is abused or neglected. The department shall: [2003, c. 673, Pt. Z, §1 (NEW).]

1. **Receive reports.** Receive reports of infants who may be affected by illegal substance abuse or suffering from withdrawal symptoms resulting from prenatal drug exposure;

[2003, c. 673, Pt. Z, §1 (NEW) .]

2. **Investigate.** Promptly investigate all reports received of infants born who may be affected by illegal substance abuse or suffering from withdrawal symptoms resulting from prenatal drug exposure;

[2003, c. 673, Pt. Z, §1 (NEW) .]

3. **Determine if infant is affected.** Determine whether or not each infant reported is affected by illegal substance abuse or suffers from withdrawal symptoms resulting from prenatal drug exposure;

[2003, c. 673, Pt. Z, §1 (NEW) .]

4. **Determine if infant is abused or neglected.** Determine whether or not the infant is abused or neglected and, if so, determine the degree of harm or threatened harm in each case;

[2003, c. 673, Pt. Z, §1 (NEW) .]

5. **Develop plan for safe care.** For each infant whom the department determines to be affected by illegal substance abuse or to be suffering from withdrawal symptoms resulting from prenatal drug exposure, develop, with the assistance of any health care provider involved in the mother's or the child's medical or mental health care, a plan for the safe care of the infant and, in appropriate cases, refer the child or mother or both to a social service agency or voluntary substance abuse prevention service; and

[2003, c. 673, Pt. Z, §1 (NEW) .]

6. **Comply with section 4004.** For each infant whom the department determines to be abused or neglected, comply with section 4004, subsection 2, paragraphs E and F.

[2003, c. 673, Pt. Z, §1 (NEW) .]

SECTION HISTORY

2003, c. 673, §Z1 (NEW).

22 §4005. PARTIES' RIGHTS TO REPRESENTATION; LEGAL COUNSEL

1. Child; guardian ad litem. The following provisions shall govern guardians ad litem. The term guardian ad litem is inclusive of lay court appointed special advocates under Title 4, chapter 31.

A. The court, in every child protection proceeding except a request for a preliminary protection order under section 4034 or a petition for a medical treatment order under section 4071, but including hearings on those orders, shall appoint a guardian ad litem for the child. The guardian ad litem's reasonable costs and expenses must be paid by the District Court. The appointment must be made as soon as possible after the proceeding is initiated. Guardians ad litem appointed on or after March 1, 2000 must meet the qualifications established by the Supreme Judicial Court. [1999, c. 251, §2 (AMD).]

B. The guardian ad litem shall act in pursuit of the best interests of the child. The guardian ad litem must be given access to all reports and records relevant to the case and investigate to ascertain the facts. The investigation must include, when possible and appropriate, the following:

(1) Review of relevant mental health records and materials;

(2) Review of relevant medical records;

(3) Review of relevant school records and other pertinent materials;

(4) Interviews with the child with or without other persons present; and

(5) Interviews with parents, foster parents, teachers, caseworkers and other persons who have been involved in caring for or treating the child.

The guardian ad litem shall have face-to-face contact with the child in the child's home or foster home within 7 days of appointment by the court and at least once every 3 months thereafter or on a schedule established by the court for reasons specific to the child and family. The guardian ad litem shall report to the court and all parties in writing at 6-month intervals, or as is otherwise ordered by the court, regarding the guardian ad litem's activities on behalf of the child and recommendations concerning the manner in which the court should proceed in the best interest of the child. The court may provide an opportunity for the child to address the court personally if the child requests to do so or if the guardian ad litem believes it is in the child's best interest. [1997, c. 715, Pt. A, §1 (AMD).]

C. The guardian ad litem may subpoena, examine and cross-examine witnesses and shall make a recommendation to the court. [1983, c. 183, (NEW).]

D. The guardian ad litem shall make a written report of the investigation, findings and recommendations and shall provide a copy of the report to each of the parties reasonably in advance of the hearing and to the court, except that the guardian ad litem need not provide a written report prior to a hearing on a preliminary protection order. The court may admit the written report into evidence. [2001, c. 696, §12 (AMD).]

E. The guardian ad litem shall make the wishes of the child known to the court if the child has expressed his

wishes, regardless of the recommendation of the guardian ad litem. [1983, c. 183, (NEW).]

F. The guardian ad litem or the child may request the court to appoint legal counsel for the child. The District Court shall pay reasonable costs and expenses of the child's legal counsel. [1995, c. 405, §20 (AMD).]

G. A person serving as a guardian ad litem under this section acts as the court's agent and is entitled to quasi-judicial immunity for acts performed within the scope of the duties of the guardian ad litem. [2001, c. 253, §4 (NEW).]

[2001, c. 696, §12 (AMD) .]

2. **Parents.** Parents and custodians are entitled to legal counsel in child protection proceedings, except a request for a preliminary protection order under section 4034 or a petition for a medical treatment order under section 4071, but including hearings on those orders. They may request the court to appoint legal counsel for them. The court, if it finds them indigent, shall appoint and pay the reasonable costs and expenses of their legal counsel.

[1983, c. 783, §2 (AMD) .]

SECTION HISTORY

1979, c. 733, §18 (NEW). 1983, c. 183, (AMD). 1983, c. 783, §§1,2 (AMD). 1985, c. 581, §2 (AMD). 1995, c. 405, §§18-20 (AMD). 1997, c. 257, §5 (AMD). 1997, c. 715, §§A1,2 (AMD). 1999, c. 251, §2 (AMD). 2001, c. 253, §4 (AMD). 2001, c. 696, §12 (AMD).

22 §4005-A. FOSTER PARENTS RIGHT TO STANDING AND INTERVENOR STATUS IN CHILD PROTECTION PROCEEDINGS

(REPEALED)

SECTION HISTORY

1985, c. 428, (NEW). 1991, c. 176, §1 (AMD). 1997, c. 343, §1 (AMD). 2001, c. 696, §13 (RP).

22 §4005-B. GRANDPARENT'S RIGHT TO STANDING AND INTERVENOR STATUS IN CHILD PROTECTION PROCEEDINGS

(REPEALED)

SECTION HISTORY

1993, c. 697, §1 (NEW). 1995, c. 290, §§3,4 (AMD). 1995, c. 694, §D36 (AMD). 1995, c. 694, §E2 (AFF). 2001, c. 58, §1 (AMD). 2001, c. 696, §14 (RP).

22 §4005-C. RIGHTS OF PERSONS WHO ARE NOT PARTIES

(REPEALED)

SECTION HISTORY

1997, c. 715, §B5 (NEW). 1999, c. 189, §1 (AMD). 1999, c. 675, §1 (AMD). 2001, c. 696, §15 (RP).

22 §4005-D. ACCESS TO AND PARTICIPATING IN PROCEEDINGS

1. **Definitions.** For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Foster parent" means a person whose home is licensed by the department as a family foster home as defined in section 8101, subsection 3 and with whom a child lives pursuant to a court order or agreement of the department. [2007, c. 255, §2 (AMD).]

B. "Grandparent" means the biological or adoptive parent of a child's biological or adoptive parent. "Grandparent" includes the parent of a child's parent whose parental rights have been terminated, but only until the child is placed for adoption. [2001, c. 696, §16 (NEW).]

C. "Interested person" means a person the court has determined as having a substantial relationship with a child or a substantial interest in the child's well-being, based on the type, strength and duration of the relationship or interest. A person may request interested person status in a child protection proceeding either orally or in writing. [2001, c. 696, §16 (NEW).]

D. "Intervenor" means a person who is granted intervenor status in a child protective proceeding pursuant to the Maine Rules of Civil Procedure, Rule 28, as long as intervention is consistent with section 4003. [2001, c. 696, §16 (NEW).]

E. "Participant" means a person who is designated as an interested person under paragraph C and who demonstrates to the court that designation as a participant is in the best interests of the child and consistent with section 4003. A person may request participant status in a child protection proceeding either orally or in writing. [2001, c. 696, §16 (NEW).]

[2007, c. 255, §2 (AMD) .]

2. **Interested persons.** Upon request, the court shall designate a foster parent, grandparent, preadoptive parent or a relative of a child by blood or marriage as an interested person unless the court finds good cause not to do so. The court may also grant interested person status to other individuals who have a significant relationship to the child, including, but not limited to, teachers, coaches, counselors or a person who has provided or is providing care for the child.

[2001, c. 696, §16 (NEW) .]

3. **Access to proceedings.** An interested person, participant or intervenor may attend and observe all court proceedings under this chapter unless the court finds good cause to exclude the person. The opportunity to attend court proceedings does not include the right to be heard or the right to present or cross-examine witnesses, present evidence or have access to pleadings or records.

[2001, c. 696, §16 (NEW) .]

4. **Right to be heard.** A participant or an intervenor has the right to be heard in any court proceeding under this chapter. The right to be heard does not include the right to present or cross-examine witnesses, present evidence or have access to pleadings or records.

[2001, c. 696, §16 (NEW) .]

5. **Intervention.** An intervenor may participate in any court proceeding under this chapter as a party as provided by the court when granting intervenor status under Maine Rules of Civil Procedure, Rule 28. An intervenor has the rights of

a party as ordered by the court in granting intervenor status, including the right to present or cross-examine witnesses, present evidence and have access to pleadings and records.

[2001, c. 696, §16 (NEW) .]

6. **Foster parents, preadoptive parents and relatives providing care.** The foster parent of a child, if any, and any preadoptive parent or relative providing care for the child must be provided notice of and the right to be heard in any proceeding to be held with respect to the child. The right to be heard includes the right to testify but does not include the right to present other witnesses or evidence, to attend any other portion of the proceeding or to have access to pleadings or records. This subsection may not be construed to require that any foster parent, preadoptive parent or relative providing care for the child be made a party to the proceeding solely on the basis of the notice and right to be heard.

The foster parent of a child, if any, and any preadoptive parent or relative providing care for the child may attend a proceeding in its entirety under this subsection unless specifically excluded by decision of the presiding judge.

[2007, c. 255, §3 (AMD) .]

7. **Confidentiality and disclosure limitations.** Interested persons, participants and intervenors are subject to the confidentiality and disclosure limitations of section 4008.

[2001, c. 696, §16 (NEW) .]

SECTION HISTORY

2001, c. 696, §16 (NEW). 2007, c. 255, §§2, 3 (AMD).

22 §4005-E. RELATIVES; VISITATION AND ACCESS; PLACEMENT

1. **Grandparent visitation and access.** A grandparent who is designated as an interested person or a participant under section 4005-D or who has been granted intervenor status under the Maine Rules of Civil Procedure, Rule 28 may request the court to grant reasonable rights of visitation or access. When a child is placed in a prospective adoptive home and the prospective adoptive parents have signed an adoptive placement agreement, a grandparent's right to contact or have access to the child that was granted pursuant to this chapter is suspended. If the adoption is not final within 18 months of adoptive placement, then the grandparent whose rights of contact or access were suspended pursuant to this subsection may resume, as a matter of right and without further court order, contact with the child in accordance with the order granting that contact or access, unless the court determines after a hearing that the contact is not in the child's best interests. A grandparent's rights of visitation or access terminate when the adoption is finalized pursuant to Title 18-A, section 9-308. Nothing in this section prohibits prospective adoptive parents from independently facilitating or permitting contact between a child and a grandparent, especially when a court has previously ordered rights of contact.

[2007, c. 371, §2 (AMD) .]

2. **Placement.** A relative who is designated as an interested person or a participant under section 4005-D or who has been granted intervenor status under the Maine Rules of Civil Procedure, Rule 28 may request the court to order that the child be placed with the relative. A relative who has not been designated as a participant under section 4005-D may make the request for placement in writing. In making a decision on the request, the court shall make placement with a relative a priority for consideration for placement if that placement is in the best interests of the child and consistent with section 4003.

[2007, c. 371, §2 (AMD) .]

3. **Conviction or adjudication for certain sex offenses; presumption.** There is a rebuttable presumption that the relative would create a situation of jeopardy for the child if any contact were to be permitted and that contact is not in the best interest of the child if the court finds that the relative:

A. Has been convicted of an offense listed in Title 19-A, section 1653, subsection 6-A, paragraph A in which the victim was a minor at the time of the offense and the relative was at least 5 years older than the minor at the time of the offense except that, if the offense was gross sexual assault under Title 17-A, section 253, subsection 1, paragraph B or C, or an offense in another jurisdiction that involves conduct that is substantially similar to that contained in Title 17-A, section 253, subsection 1, paragraph B or C, and the minor victim submitted as a result of compulsion, the presumption applies regardless of the ages of the relative and the minor victim at the time of the offense; or [2007, c. 513, §5 (AMD).]

B. Has been adjudicated in an action under Title 22, chapter 1071 of sexually abusing a person who was a minor at the time of the abuse. [2005, c. 366, §6 (NEW).]

The relative seeking visitation with or access to the child may produce evidence to rebut the presumption.

[2007, c. 371, §2 (AMD); 2007, c. 513, §5 (AMD) .]

SECTION HISTORY

2001, c. 696, §16 (NEW). 2005, c. 366, §6 (AMD). 2007, c. 371, §2 (AMD). 2007, c. 513, §5 (AMD).

22 §4005-F. DETERMINATIONS OF PARENTAGE

As part of a child protection proceeding, the District Court may determine parentage of the child. Title 19-A, sections 1558 to 1564 apply to determinations of parentage in a child protection proceeding. [2007, c. 257, §1 (NEW).]

This section may not be construed to limit the right of a person to file an action pursuant to Title 19-A, chapter 53, subchapter 1 to enforce a father's obligations pursuant to that subchapter. [2007, c. 257, §1 (NEW).]

SECTION HISTORY

2007, c. 257, §1 (NEW).

22 §4006. APPEALS

A party aggrieved by an order of a court entered pursuant to section 4035, 4054 or 4071 may appeal directly to the Supreme Judicial Court sitting as the Law Court and such appeals are governed by the Maine Rules of Civil Procedure, chapter 9. [1997, c. 715, Pt. A, §3 (RPR).]

Appeals from any order under section 4035, 4054 or 4071 must be expedited. Any attorney appointed to represent a party in a District Court proceeding under this chapter shall continue to represent that client in any appeal unless otherwise ordered by the court. [1997, c. 715, Pt. A, §3 (RPR).]

Orders entered under this chapter under sections other than section 4035, 4054 or 4071 are interlocutory and are not appealable. [1997, c. 715, Pt. A, §3 (RPR).]

SECTION HISTORY

1979, c. 733, §18 (NEW). 1983, c. 772, §3 (AMD). 1997, c. 715, §A3 (RPR).

22 §4007. CONDUCTING PROCEEDINGS

1. **Procedures.** All child protection proceedings shall be conducted according to the rules of civil procedure and the rules of evidence, except as provided otherwise in this chapter. All the proceedings shall be recorded. All proceedings and records shall be closed to the public, unless the court orders otherwise.

[1985, c. 495, §17 (AMD) .]

1-A. **Nondisclosure of certain identifying information.** This subsection governs the disclosure of certain identifying information.

A. At each proceeding, the court shall inquire whether there are any court orders in effect at the time of the proceeding that prohibit contact between the parties and participants. If such an order is in effect at the time of the proceeding, the court shall keep records that pertain to the protected person's current or intended address or location confidential, subject to disclosure only as authorized in this section. Any records in the file that contain such information must be sealed by the clerk and not disclosed to other parties or their attorneys or authorized agents unless the court orders the disclosure to be made after a hearing in which the court takes into consideration the health, safety or liberty of the protected person and determines that the disclosure is in the interests of justice. [2007, c. 351, §2 (NEW).]

B. If, at any stage of the proceedings, a party or a participant alleges in an affidavit or a pleading under oath that the health, safety or liberty of the person would be jeopardized by disclosure of information pertaining to the person's current or intended address or location, the court shall keep records that contain the information confidential, subject to disclosure only as authorized in this section. Upon receipt of the affidavit or pleading, the records in the file that contain such information must be sealed by the clerk and not disclosed to other parties or participants or their attorneys or authorized agents unless the court orders the disclosure to be made after a hearing in which the court takes into consideration the health, safety or liberty of the person seeking protection and determines that the disclosure is in the interests of justice. [2007, c. 351, §2 (NEW).]

C. If the current or intended address or location of a party or participant is required to be kept confidential under paragraph A or B, and the current or intended address or location of that person is a material fact necessary to the proceeding, the court shall hear the evidence outside of the presence of the person and the person's attorney from whom the information is being kept confidential unless the court determines after a hearing that takes into consideration the health, safety or liberty of the protected person that the exclusion of the party or participant is not in the interests of justice. If such evidence is taken outside the presence of a party or participant, the court shall take measures to prevent the excluded person and the person's attorney from accessing the recorded information and the information must be redacted in printed transcripts. [2007, c. 351, §2 (NEW).]

D. Records that are required to be maintained by the court as confidential under this subsection may be disclosed to:

(1) A state agency if necessary to carry out the statutory function of that agency;

(2) A guardian ad litem appointed to the case; or

(3) A criminal justice agency, as defined by Title 16, section 611, if necessary to carry out the administration of criminal justice or the administration of juvenile justice, and such disclosure is otherwise permitted pursuant to section 4008.

In making such disclosure, the court shall order the party receiving the information to maintain the information as confidential. [2007, c. 351, §2 (NEW).]

[2007, c. 351, §2 (NEW) .]

2. **Interviewing children.** The court may interview a child witness in chambers, with only the guardian ad litem and counsel present, provided that the statements made are a matter of record. The court may admit and consider oral or written evidence of out-of-court statements made by a child, and may rely on that evidence to the extent of its probative value.

[1979, c. 733, §18 (NEW) .]

3. **Motion for examination.** At any time during the proceeding, the court may order that a child, parent, alleged parent, person frequenting the household or having custody at the time of the alleged abuse or neglect, any other party to the action or person seeking care or custody of the child be examined pursuant to the Maine Rules of Civil Procedure, Rule 35.

[1989, c. 270, §1 (AMD) .]

3-A. **Report of licensed mental health professional.** In any hearing held in connection with a child protection proceeding under this chapter, the written report of a licensed mental health professional who has treated or evaluated the child shall be admitted as evidence, provided that the party seeking admission of the written report has furnished a copy of the report to all parties at least 21 days prior to the hearing. The report shall not be admitted as evidence without the testimony of the mental health professional if a party objects at least 7 days prior to the hearing. This subsection does not apply to the caseworker assigned to the child.

[1989, c. 226, (NEW) .]

4. **Interstate compact.** The provisions of the Interstate Compact for the Placement of Children, sections 4251 to 4269, if in effect and ratified by the other state involved, apply to proceedings under this chapter; otherwise, the provisions of the Interstate Compact on Placement of Children, sections 4191 to 4287, apply to proceedings under this chapter. Any report submitted pursuant to the compact is admissible in evidence for purposes of indicating compliance with the compact and the court may rely on evidence to the extent of its probative value.

[2007, c. 255, §4 (AMD) .]

5. **Records.**

[2005, c. 300, §1 (RP) .]

6. **Benefits and support for children in custody of department.** When a child has been ordered into the custody of the department under this chapter, Title 15, chapter 507 or Title 19-A, chapter 55, within 30 days of the order, each parent shall provide the department with information necessary for the department to make a determination regarding the eligibility of the child for state, federal or other 3rd-party benefits and shall provide any necessary authorization for the department to apply for these benefits for the child.

Prior to a hearing under section 4034, subsection 4, section 4035 or section 4038, each parent shall file income affidavits as required by Title 19-A, sections 2002 and 2004 unless current information is already on file with the court. If a child is placed in the custody of the department, the court shall order child support from each parent according to the guidelines pursuant to Title 19-A, chapter 63, designate each parent as a nonprimary care provider and apportion the obligation accordingly.

Income affidavits and instructions must be provided to each parent by the department at the time of service of the petition or motion. The court may order a deviation pursuant to Title 19-A, section 2007. Support ordered pursuant to this section must be paid directly to the department pursuant to Title 19-A, chapter 65, subchapter IV. The failure of a

parent to file an affidavit does not prevent the entry of a protection order. A parent may be subject to Title 19-A, section 2004, subsection 1, paragraph D for failure to complete and file income affidavits.

[1995, c. 694, Pt. D, §37 (AMD); 1995, c. 694, Pt. E, §2 (AFF) .]

SECTION HISTORY

1979, c. 733, §18 (NEW). 1983, c. 772, §4 (AMD). 1983, c. 783, §3 (AMD). 1985, c. 495, §17 (AMD). 1985, c. 506, §§A41,42 (AMD). 1989, c. 226, (AMD). 1989, c. 270, §1 (AMD). 1991, c. 840, §6 (AMD). 1993, c. 288, §1 (AMD). 1995, c. 694, §D37 (AMD). 1995, c. 694, §E2 (AFF). 2005, c. 300, §1 (AMD). 2007, c. 255, §4 (AMD). 2007, c. 351, §2 (AMD).

22 §4008. RECORDS; CONFIDENTIALITY; DISCLOSURE

1. **Confidentiality of records and information.** All department records that contain personally identifying information and are created or obtained in connection with the department's child protective activities and activities related to a child while in the care or custody of the department, and all information contained in those records, are confidential and subject to release only under the conditions of subsections 2 and 3.

Within the department, the records are available only to and may be used only by appropriate departmental personnel and legal counsel for the department in carrying out their functions.

Any person who receives department records or information from the department may use the records or information only for the purposes for which that release was intended.

[2007, c. 485, §1 (AMD); 2007, c. 485, §2 (AFF) .]

2. **Optional disclosure of records.** The department may disclose relevant information in the records to the following persons:

A. An agency or person investigating or participating on a team investigating a report of child abuse or neglect when the investigation or participation is authorized by law or by an agreement with the department; [1987, c. 511, Pt. B, §1 (RPR).]

A-1. A law enforcement agency, to the extent necessary for reporting, investigating and prosecuting an alleged crime, the victim of which is a department employee, an employee of the Attorney General's Office, an employee of any court or court system, a person mandated to report suspected abuse or neglect, a person who has made a report to the department, a person who has provided information to the department or an attorney, guardian ad litem, party, participant, witness or prospective witness in a child protection proceeding; [2005, c. 300, §3 (NEW).]

B. [1983, c. 327, §3 (RP).]

C. A physician treating a child whom he reasonably suspects may be abused or neglected; [1979, c. 733, §18 (NEW).]

D. A child named in a record who is reported to be abused or neglected, or the child's parent or custodian, or the subject of the report, with protection for identity of reporters and other persons when appropriate; [1987, c. 744, §3 (AMD).]

D-1. A parent, custodian or caretaker of a child when the department believes the child may be at risk of harm from the person who is the subject of the records or information, with protection for identity of reporters and other persons when appropriate; [2005, c. 300, §4 (NEW).]

D-2. A party to a child protection proceeding, when the records or information is relevant to the proceeding, with

protection for identity of reporters and other persons when appropriate; [2005, c. 300, §4 (NEW).]

E. A person having the legal responsibility or authorization to evaluate, treat, educate, care for or supervise a child, parent or custodian who is the subject of a record, or a member of a panel appointed by the department to review child deaths and serious injuries, or a member of the Domestic Abuse Homicide Review Panel established under Title 19-A, section 4013, subsection 4. This includes a member of a treatment team or group convened to plan for or treat a child or family that is the subject of a record. This may also include a member of a support team for foster parents, if that team has been reviewed and approved by the department; [2005, c. 300, §5 (AMD).]

E-1. [2007, c. 371, §3 (RP).]

F. Any person engaged in bona fide research, provided that no personally identifying information is made available, unless it is essential to the researcher and the commissioner or the commissioner's designee gives prior approval. If the researcher desires to contact a subject of a record, the subject's consent shall be obtained by the department prior to the contact; [1989, c. 270, §2 (RPR).]

G. Any agency or department involved in licensing or approving homes for, or the placement of, children or dependent adults, with protection for identity of reporters and other persons when appropriate; [1989, c. 270, §3 (RPR).]

H. Persons and organizations pursuant to Title 5, section 9057, subsection 6, and pursuant to chapter 857; [1989, c. 270, §4 (RPR); 1989, c. 502, Pt. A, §76 (RPR); 1989, c. 878, Pt. A, §62 (RPR).]

I. The representative designated to provide child welfare services by the tribe of an Indian child as defined by the federal Indian Child Welfare Act, 25 United States Code, Section 1903, or a representative designated to provide child welfare services by an Indian tribe of Canada; [2007, c. 140, §5 (AMD).]

J. A person making a report of suspected abuse or neglect. The department may only disclose that it has not accepted the report for investigation, unless other disclosure provisions of this section apply; and [2007, c. 140, §6 (AMD).]

K. The local animal control officer or the animal welfare program of the Department of Agriculture, Food and Rural Resources established pursuant to Title 7, section 3902 when there is a reasonable suspicion of animal cruelty, abuse or neglect. For purposes of this paragraph, "cruelty, abuse or neglect" has the same meaning as provided in Title 34-B, section 1901, subsection 1, paragraph B. [2007, c. 140, §7 (NEW).]

[2007, c. 140, §§5-7 (AMD); 2007, c. 371, §3 (AMD) .]

3. **Mandatory disclosure of records.** The department shall disclose relevant information in the records to the following persons:

A. The guardian ad litem of a child, appointed pursuant to section 4005, subsection 1; [2005, c. 300, §8 (AMD).]

A-1. The court-appointed guardian ad litem, visitor or attorney of a child who is the subject of a court proceeding involving parental rights and responsibilities, grandparent visitation, custody, guardianship or involuntary commitment. The access of the guardian ad litem, visitor or attorney to the records or information under this paragraph is limited to reviewing the records in the offices of the department. Any other use of the information or records during the proceeding in which the guardian ad litem, visitor or attorney is appointed is governed by paragraph B; [2005, c. 300, §9 (NEW).]

B. A court on its finding that access to those records may be necessary for the determination of any issue before the court or a court requesting a home study from the department pursuant to Title 18-A, section 9-304 or Title 19-A, section 905. Access to such a report or record is limited to counsel of record unless otherwise ordered by the

court. Access to actual reports or records is limited to in camera inspection, unless the court determines that public disclosure of the information is necessary for the resolution of an issue pending before the court; [1995, c. 694, Pt. D, §38 (AMD); 1995, c. 694, Pt. E, §2 (AFF).]

C. A grand jury on its determination that access to those records is necessary in the conduct of its official business; [1983, c. 327, §4 (AMD); 1983, c. 470, §12 (AMD).]

D. An appropriate state executive or legislative official with responsibility for child protection services, provided that no personally identifying information may be made available unless necessary to that official's functions; [2001, c. 439, Pt. X, §2 (AMD).]

E. The protection and advocacy agency for persons with disabilities, as designated pursuant to Title 5, section 19502, in connection with investigations conducted in accordance with Title 5, chapter 511. The determination of what information and records are relevant to the investigation must be made by agreement between the department and the agency; [1991, c. 630, §2 (AMD).]

F. The Commissioner of Education when the information concerns teachers and other professional personnel issued certificates under Title 20-A, persons employed by schools approved pursuant to Title 20-A or any employees of schools operated by the Department of Education; [2001, c. 696, §18 (AMD).]

G. The prospective adoptive parents. Prior to a child being placed for the purpose of adoption, the department shall comply with the requirements of Title 18-A, section 9-304, subsection (b) and section 8205; [2003, c. 673, Pt. Z, §2 (AMD).]

H. Upon written request, a person having the legal authorization to evaluate or treat a child, parent or custodian who is the subject of a record. This includes a member of a treatment team or group convened to plan for or treat a child or family that is the subject of a record; [2003, c. 673, Pt. Z, §3 (AMD).]

I. Any government entity that needs such information in order to carry out its responsibilities under law to protect children from abuse and neglect. For purposes of this paragraph, "government entity" means a federal entity, a state entity of any state, a local government entity of any state or locality or an agent of a federal, state or local government entity; [2007, c. 371, §4 (AMD).]

J. To a juvenile court when the child who is the subject of the records has been brought before the court pursuant to Title 15, Part 6; and [2007, c. 371, §5 (AMD).]

K. A relative or other person whom the department is investigating for possible custody or placement of the child. [2007, c. 371, §6 (NEW).]

[2007, c. 371, §§4-6 (AMD) .]

3-A. **Confidentiality.** The proceedings and records of the child death and serious injury review panel created in accordance with section 4004, subsection 1, paragraph E are confidential and are not subject to subpoena, discovery or introduction into evidence in a civil or criminal action. The commissioner shall disclose conclusions of the review panel upon request, but may not disclose data that is otherwise classified as confidential.

[1993, c. 294, §4 (NEW) .]

4. **Unlawful dissemination; penalty.** A person is guilty of unlawful dissemination if he knowingly disseminates records which are determined confidential by this section, in violation of the mandatory or optional disclosure provisions of this section. Unlawful dissemination is a Class E crime, which, notwithstanding Title 17-A, section 1252, subsection 2, paragraph E, is punishable by a fine of not more than $500 or by imprisonment for not more than 30 days.

[1989, c. 502, Pt. D, §18 (AMD) .]

5. **Retention of unsubstantiated child protection services records.** Except as provided in this subsection, the department shall retain unsubstantiated child protective services case records for no more than 18 months following a finding of unsubstantiation and then expunge unsubstantiated case records from all departmental files or archives unless a new referral has been received within the 18-month retention period. Unsubstantiated child protective services records of persons who were eligible for Medicaid services under the federal Social Security Act, Title XIX, at the time of the investigation may be retained for up to 5 years for the sole purpose of state and federal audits of the Medicaid program. Unsubstantiated child protective services case records retained for audit purposes pursuant to this subsection must be stored separately from other child protective services records and may not be used for any other purpose.

[1989, c. 857, §58 (AMD) .]

6. **Requests for disclosure of records; establishment of fees; rules.** The department may accept requests and charge fees for research and disclosure of its records as provided in this subsection.

A. The department may charge fees for the services listed in paragraph B to any person except the following:

(1) A parent in a child protection proceeding, an attorney who represents a parent in a child protection proceeding or a guardian ad litem in a child protection proceeding when the parent, attorney or guardian ad litem requests the service for the purposes of the child protection proceeding;

(2) An adoptive parent or prospective adoptive parent who requests records relating to the child who has been or might be adopted;

(3) A person having the legal authorization to evaluate or treat a child, parent or custodian who is the subject of a record, including a member of a treatment team or group convened to plan for or treat a child or family that is the subject of a record; the record must be requested for the purpose of evaluating or treating the child, parent or custodian who is the subject of the record;

(4) Governmental entities of this State that are not engaged in licensing; and

(5) Governmental entities of any county or municipality of this State that are not engaged in licensing.

A request or order by a court for disclosure of records pursuant to subsection 3, paragraph B must be deemed to have been made by the person requesting that the court order the disclosure. [2003, c. 673, Pt. W, §1 (NEW).]

B. The department may charge fees for the following services:

(1) Researching its records to determine whether a particular person is named in the records;

(2) Receiving and responding to a request for disclosure of department records, whether or not the department grants the request; and

(3) Disclosing department records. [2003, c. 673, Pt. W, §1 (NEW).]

C. The department may adopt rules governing requests for the services listed in paragraph B. Those rules may provide for a mechanism for making a request, the information required in making a request, the circumstances under which requests will be granted or denied and any other matter that the department determines necessary to efficiently respond to requests for disclosure of records. Rules adopted pursuant to this paragraph are routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A. [2003, c. 673, Pt. W, §1 (NEW).]

D. The department shall establish a schedule of fees by rule. The schedule of fees may provide that certain classes

of persons are exempt from the fees, and it may establish different fees for different classes of persons. All fees collected by the department must be deposited in the General Fund. Rules adopted pursuant to this paragraph are routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A. [2003, c. 673, Pt. W, §1 (NEW).]

E. A governmental entity that is engaged in licensing may charge an applicant for the fees imposed on it by the department for research and disclosure of records. [2003, c. 673, Pt. W, §1 (NEW).]

F. This subsection may not be construed to permit or require the department to make a disclosure in any particular case. [2003, c. 673, Pt. W, §1 (NEW).]

[2003, c. 673, Pt. W, §1 (NEW) .]

SECTION HISTORY

1979, c. 733, §18 (NEW). 1983, c. 327, §§3-5 (AMD). 1983, c. 354, §§1,2 (AMD). 1983, c. 470, §§12,13 (AMD). 1983, c. 783, §4 (AMD). 1985, c. 495, §18 (AMD). 1985, c. 506, §§A43-45 (AMD). 1985, c. 739, §§5,6 (AMD). 1987, c. 511, §§A3,B1 (AMD). 1987, c. 714, §§5-7 (AMD). 1987, c. 744, §§3-7 (AMD). 1989, c. 118, (AMD). 1989, c. 270, §§2-5 (AMD). 1989, c. 483, §A33 (AMD). 1989, c. 502, §§A76,77,D18 (AMD). 1989, c. 700, §A89 (AMD). 1989, c. 857, §58 (AMD). 1989, c. 878, §§A62,63 (AMD). 1991, c. 630, §§2-4 (AMD). 1993, c. 294, §3 (AMD). 1993, c. 294, §4 (AMD). 1993, c. 686, §8 (AMD). 1993, c. 686, §13 (AFF). 1995, c. 391, §2 (AMD). 1995, c. 694, §§D38,39 (AMD). 1995, c. 694, §E2 (AFF). 2001, c. 439, §X2 (AMD). 2001, c. 696, §§17-20 (AMD). 2003, c. 673, §§W1,Z2-4 (AMD). 2005, c. 300, §§2-9 (AMD). 2007, c. 140, §§5-7 (AMD). 2007, c. 335, §1-3 (AMD). 2007, c. 371, §§3-6 (AMD). 2007, c. 485, §1 (AMD). 2007, c. 335, §5 (AFF). 2007, c. 473, §1 (AFF). 2007, c. 485, §2 (AFF).

22 §4008-A. CHILD ABUSE AND NEGLECT INVESTIGATIONS; DISCLOSURE

1. **Disclosure permitted.** Notwithstanding any other provision of law, the commissioner, with the advice of the Attorney General, may disclose information as set forth in this section regarding the abuse or neglect of a child and the investigation of and any services related to the abuse and neglect if the commissioner determines that such disclosure is not contrary to the best interests of the child, the child's siblings or other children in the household and any one of the following factors is present:

A. The alleged perpetrator of the abuse or neglect has been charged with committing a crime related to the allegation of abuse or neglect maintained by the department; [1997, c. 328, §1 (NEW).]

B. A judge, a law enforcement agency official, a district attorney or another state or local investigative agency or official has publicly disclosed, as required by law in the performance of official duties, the provision of child welfare services or the investigation by child welfare services of the abuse or neglect of the child; [1997, c. 328, §1 (NEW).]

C. An individual who is the parent, custodian or guardian of the victim or a child victim over 14 years of age has made a prior knowing, voluntary, public disclosure; or [1997, c. 328, §1 (NEW).]

D. The child named in the report has died. [1997, c. 328, §1 (NEW).]

[1997, c. 328, §1 (NEW) .]

2. **Information.** For the purposes of this section, the following information may be disclosed:

A. The name and age of the abused or neglected child. If the child is under 13 years of age, the guardian ad litem must agree with the commissioner to release the information. If the child is 13 years of age or older, the guardian ad litem and the child must agree with the commissioner to release the information; [1997, c. 328, §1 (NEW).]

B. The determination by the local child protective service or the state agency that investigated the alleged abuse or neglect and the findings of the applicable investigating agency upon which the determination was based; [1997, c. 328, §1 (NEW).]

C. Identification of child protective or other services provided or actions, if any, taken regarding the child and the child's family; [1997, c. 328, §1 (NEW).]

D. Whether any report of abuse or neglect regarding the child has been substantiated as maintained by the department; [1997, c. 328, §1 (NEW).]

E. Any actions taken by child protective services in response to reports of abuse or neglect of the child to the department, including, but not limited to, actions taken after every report of abuse or neglect of the child and the dates of the reports; [1997, c. 328, §1 (NEW).]

F. Whether the child or the child's family has received care or services from the child welfare services prior to every report of abuse or neglect of the child; and [1997, c. 328, §1 (NEW).]

G. Any extraordinary or pertinent information concerning the circumstances of the abuse or neglect of the child and the investigation of the abuse or neglect, if the commissioner determines the disclosure is consistent with the public interest. [1997, c. 328, §1 (NEW).]

[1997, c. 328, §1 (NEW) .]

3. **Limitations.** The following limitations apply to information disclosed pursuant to this section.

A. Information released prior to the completion of the investigation of a report must be limited to a statement that a report is under investigation. [1997, c. 328, §1 (NEW).]

B. If there has been a prior disclosure pursuant to paragraph A, information released in a case in which the report has not been substantiated is limited to the statement that the investigation has been completed and the report has not been substantiated. [1997, c. 328, §1 (NEW).]

C. If the report has been substantiated, information may be released pursuant to subsection 2. [1997, c. 328, §1 (NEW).]

D. The disclosure may not identify or provide any identifying description of the source of the report, and may not identify the name of the abused or neglected child's siblings, the parent or other person legally responsible for the child or any other members of the child's household, other than the subject of the report. [1997, c. 328, §1 (NEW).]

[1997, c. 328, §1 (NEW) .]

4. **Considerations.** In determining pursuant to subsection 1 whether disclosure would be contrary to the best interests of the child, the child's siblings or other children in the household, the commissioner shall consider the privacy of the child and the child's family and the effects that disclosure may have on efforts to reunite and provide services to the family.

[1997, c. 328, §1 (NEW) .]

5. **Other releases and disclosure.** Except as it applies directly to the cause of the abuse or neglect of the child, nothing in this section authorizes the release or disclosure of the substance or content of any psychological, psychiatric, therapeutic, clinical or medical reports, evaluations or similar materials or information pertaining to the child or the child's family.

[1997, c. 328, §1 (NEW) .]

SECTION HISTORY

1997, c. 328, §1 (NEW).

22 §4009. PENALTY FOR VIOLATIONS

A person who knowingly violates a provision of this chapter commits a civil violation for which a forfeiture of not more than $500 may be adjudged. [1979, c. 733, §18 (NEW).]

SECTION HISTORY

1979, c. 733, §18 (NEW).

22 §4010. SPIRITUAL TREATMENT

1. **Treatment not considered abuse or neglect.** Under subchapters I to VII, a child shall not be considered to be abused or neglected, in jeopardy of health or welfare or in danger of serious harm solely because treatment is by spiritual means by an accredited practitioner of a recognized religious organization.

[1979, c. 733, §18 (NEW) .]

2. **Treatment to be considered if requested.** When medical treatment is authorized under this chapter, treatment by spiritual means by an accredited practitioner of a recognized religious organization may also be considered if requested by the child or his parent.

[1979, c. 733, §18 (NEW) .]

SECTION HISTORY

1979, c. 733, §18 (NEW).

22 §4010-A. CHILD ABUSE POLICIES

1. **Policy development.** Every public or private agency or program that is administered, licensed or funded by the Department of Health and Human Services or the Department of Corrections and hires staff or selects volunteers and provides care or services for children shall develop a written policy regarding child abuse and neglect.

The policy must include:

A. A description of how the program and children are managed to prevent abuse or neglect; [2003, c. 2, §78 (COR).]

B. The reporting of suspected abuse or neglect or other violations to the appropriate designated authorities; [1989, c. 223, (NEW).]

C. The agency's course of action if allegations of abuse or neglect are made against the agency or its staff; and [1989, c. 223, (NEW).]

D. The agency's grievance procedures for staff and for children and their parents or guardians regarding alleged abuse or neglect. [2003, c. 2, §78 (COR).]

[2003, c. 2, §78 (COR) .]

2. **Filing.** The agency shall file the policy as part of its application for licensure or renewal with the state entity that regulates the agency within one year of the effective date of this subsection or of the date the agency comes into existence.

[1989, c. 223, (NEW) .]

3. **Availability of policy.** The agency shall make the policy available to its staff, clients and the public.

[1989, c. 223, (NEW) .]

SECTION HISTORY

1989, c. 223, (NEW). 1989, c. 819, §1 (AMD). 1995, c. 560, §K82 (AMD). 1995, c. 560, §K83 (AFF). 2001, c. 354, §3 (AMD). RR 2003, c. 2, §78 (COR).

22 §4010-B. WRITTEN POLICIES

1. **Written policies.** By February 1, 2003, the department shall put in writing all policies that direct or guide procedural and substantive decision making by caseworkers, supervisors and other department personnel concerning child protective cases.

[2001, c. 696, §21 (NEW) .]

2. **Publicly available.** By February 1, 2003, the department shall make available to the public all policies that direct or guide procedural and substantive decision making by caseworkers, supervisors and other department personnel concerning child protective cases. The department shall post and maintain the policies on a publicly accessible site on the Internet.

[2001, c. 696, §21 (NEW) .]

3. **Kinship care policies.** By September 1, 2002, the department shall make kinship care policies available in writing to the public.

[2001, c. 696, §21 (NEW) .]

4. **Rules.** This section does not affect the department's responsibility to adopt rules as otherwise required by law.

[2001, c. 696, §21 (NEW) .]

SECTION HISTORY

2001, c. 696, §21 (NEW).

Subchapter 2: REPORTING OF ABUSE OR NEGLECT

22 §4011. PERSONS MANDATED TO REPORT SUSPECTED ABUSE OR NEGLECT

(REPEALED)

SECTION HISTORY

1979, c. 733, §18 (NEW). 1983, c. 354, §3 (AMD). 1985, c. 495, §§19,20 (AMD). 1985, c. 530, §1 (AMD). 1985, c. 739, §7 (AMD). 1985, c. 819, §§A25,26 (AMD). 1987, c. 744, §8 (AMD). 1989, c. 270, §6 (AMD). 1989, c. 819, §2 (AMD). 1997, c. 251, §1 (AMD). 1999, c. 300, §§1,2 (AMD). 2001, c. 345, §4 (RP).

22 §4011-A. REPORTING OF SUSPECTED ABUSE OR NEGLECT

1. **Required report to department.** The following adult persons shall immediately report or cause a report to be made to the department when the person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that a suspicious child death has occurred:

Whenever a person is required to report in a capacity as a member of the staff of a medical or public or private institution, agency or facility, that person immediately shall notify either the person in charge of the institution, agency or facility or a designated agent who then shall cause a report to be made. The staff also may make a report directly to the department.

A. When acting in a professional capacity:

(1) An allopathic or osteopathic physician, resident or intern;

(2) An emergency medical services person;

(3) A medical examiner;

(4) A physician's assistant;

(5) A dentist;

(6) A dental hygienist;

(7) A dental assistant;

(8) A chiropractor;

(9) A podiatrist;

(10) A registered or licensed practical nurse;

(11) A teacher;

(12) A guidance counselor;

(13) A school official;

(14) A children's summer camp administrator or counselor;

(15) A social worker;

(16) A court-appointed special advocate or guardian ad litem for the child;

(17) A homemaker;

(18) A home health aide;

(19) A medical or social service worker;

(20) A psychologist;

(21) Child care personnel;

(22) A mental health professional;

(23) A law enforcement official;

(28) A state or municipal fire inspector;

(25) A municipal code enforcement official;

(26) A commercial film and photographic print processor;

(27) A clergy member acquiring the information as a result of clerical professional work except for information received during confidential communications;

(28) A chair of a professional licensing board that has jurisdiction over mandated reporters;

(29) A humane agent employed by the Department of Agriculture, Food and Rural Resources;

(30) A sexual assault counselor; and

(31) A family or domestic violence victim advocate; [2007, c. 577, §6 (AMD).]

B. Any person who has assumed full, intermittent or occasional responsibility for the care or custody of the child, regardless of whether the person receives compensation; and [2003, c. 210, §3 (AMD).]

C. Any person affiliated with a church or religious institution who serves in an administrative capacity or has otherwise assumed a position of trust or responsibility to the members of that church or religious institution, while acting in that capacity, regardless of whether the person receives compensation. [2003, c. 210, §4 (NEW).]

[2007, c. 577, §6 (AMD); 2007, c. 586, §10 (AMD) .]

1-A. **Permitted reporters.** An animal control officer, as defined in Title 7, section 3907, subsection 4, may report to the department when that person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected.

[2007, c. 139, §2 (NEW) .]

2. **Required report to district attorney.** When, while acting in a professional capacity, any person required to report under this section knows or has reasonable cause to suspect that a child has been abused or neglected by a person not responsible for the child or that a suspicious child death has been caused by a person not responsible for the child, the person immediately shall report or cause a report to be made to the appropriate district attorney's office.

[2007, c. 586, §11 (AMD) .]

3. **Optional report.** Any person may make a report if that person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that there has been a suspicious child death.

[2007, c. 586, §12 (AMD) .]

4. **Mental health treatment.** When a licensed mental health professional is required to report under subsection 1 and the knowledge or reasonable cause to suspect that a child has been or is likely to be abused or neglected or that a

suspicious child death has occurred comes from treatment of a person responsible for the abuse , neglect or death, the licensed mental health professional shall report to the department in accordance with subsection 1 and under the following conditions.

A. The department shall consult with the licensed mental health professional who has made the report and shall attempt to reach agreement with the mental health professional as to how the report is to be pursued. If agreement is not reached, the licensed mental health professional may request a meeting under paragraph B. [2001, c. 345, §5 (NEW).]

B. Upon the request of the licensed mental health professional who has made the report, after the department has completed its investigation of the report under section 4021 or has received a preliminary protection order under section 4034 and when the department plans to initiate or has initiated a jeopardy order under section 4035 or plans to refer or has referred the report to law enforcement officials, the department shall convene at least one meeting of the licensed mental health professional who made the report, at least one representative from the department, a licensed mental health professional with expertise in child abuse or neglect and a representative of the district attorney's office having jurisdiction over the report, unless that office indicates that prosecution is unlikely. [2001, c. 345, §5 (NEW).]

C. The persons meeting under paragraph B shall make recommendations regarding treatment and prosecution of the person responsible for the abuse , neglect or death. The persons making the recommendations shall take into account the nature, extent and severity of abuse or neglect, the safety of the child and the community and needs of the child and other family members for treatment of the effects of the abuse or neglect and the willingness of the person responsible for the abuse , neglect or death to engage in treatment. The persons making the recommendations may review or revise these recommendations at their discretion. [2007, c. 586, §13 (AMD).]

The intent of this subsection is to encourage offenders to seek and effectively utilize treatment and, at the same time, provide any necessary protection and treatment for the child and other family members.

[2007, c. 586, §13 (AMD) .]

5. **Photographs of visible trauma.** Whenever a person is required to report as a staff member of a law enforcement agency or a hospital, that person shall make reasonable efforts to take, or cause to be taken, color photographs of any areas of trauma visible on a child.

A. The taking of photographs must be done with minimal trauma to the child and in a manner consistent with professional standards. The parent's or custodian's consent to the taking of photographs is not required. [2001, c. 345, §5 (NEW).]

B. Photographs must be made available to the department as soon as possible. The department shall pay the reasonable costs of the photographs from funds appropriated for child welfare services. [2001, c. 345, §5 (NEW).]

C. The person shall notify the department as soon as possible if that person is unable to take, or cause to be taken, these photographs. [2001, c. 345, §5 (NEW).]

D. Designated agents of the department may take photographs of any subject matter when necessary and relevant to an investigation of a report of suspected abuse or neglect or to subsequent child protection proceedings. [2001, c. 345, §5 (NEW).]

[2001, c. 345, §5 (NEW) .]

6. **Permissive reporting of animal cruelty, abuse or neglect.** Notwithstanding any other provision of state law imposing a duty of confidentiality, a person listed in subsection 1 may report a reasonable suspicion of animal cruelty,

abuse or neglect to the local animal control officer or to the animal welfare program of the Department of Agriculture, Food and Rural Resources established pursuant to Title 7, section 3902. For purposes of this subsection, the reporter shall disclose only such limited confidential information as is necessary for the local animal control officer or animal welfare program employee to identify the animal's location and status and the owner's name and address. For purposes of this subsection, "cruelty, abuse or neglect" has the same meaning as provided in Title 34-B, section 1901, subsection 1, paragraph B. A reporter under this subsection may assert immunity from civil and criminal liability under Title 34-B, chapter 1, subchapter 6.

[2007, c. 140, §8 (NEW) .]

SECTION HISTORY

2001, c. 345, §5 (NEW). 2003, c. 145, §2 (AMD). 2003, c. 210, §§3,4 (AMD). 2003, c. 510, §E3 (AMD). 2003, c. 599, §8 (AMD). 2003, c. 510, §E4 (AFF). 2003, c. 599, §§9,14 (AFF). 2007, c. 139, §2 (AMD). 2007, c. 140, §8 (AMD). 2007, c. 577, §6 (AMD). 2007, c. 586, §§10-13 (AMD).

22 §4011-B. REPORTING OF PRENATAL EXPOSURE TO DRUGS

1. **Reporting of infants with prenatal exposure to drugs.** A health care provider involved in the delivery or care of an infant who the provider knows or has reasonable cause to suspect has been born affected by illegal substance abuse or is suffering from withdrawal symptoms resulting from prenatal drug exposure, whether or not the prenatal exposure was to legal or illegal drugs, shall notify the department of that condition in the infant. The report required by this subsection must be made in the same manner as reports of abuse or neglect required by this subchapter.

A. This section, and any notification made pursuant to this section, may not be construed to establish a definition of "abuse" or "neglect. " [2003, c. 673, Pt. Z, §5 (NEW).]

B. This section, and any notification made pursuant to this section, may not be construed to require prosecution for any illegal action, including, but not limited to, the act of exposing a fetus to drugs or other substances. [2003, c. 673, Pt. Z, §5 (NEW).]

[2003, c. 673, Pt. Z, §5 (NEW) .]

2. **Definition.** For purposes of this section, "health care provider" means a person described in section 4011-A, subsection 1, paragraph A, subparagraphs (1) to (10), (15), (17) to (20) or (22) or any person who assists in the delivery or birth of a child for compensation, including, but not limited to, a midwife.

[2003, c. 673, Pt. Z, §5 (NEW) .]

SECTION HISTORY

2003, c. 673, §Z5 (NEW).

22 §4012. REPORTING PROCEDURES

1. **Immediate report.** Reports regarding abuse or neglect shall be made immediately by telephone to the department and shall be followed by a written report within 48 hours if requested by the department.

[1979, c. 733, §18 (NEW) .]

2. **Information required.** The reports shall include the following information if within the knowledge of the person reporting:

A. The name and address of the child and the persons responsible for his care or custody; [1979, c. 733, §18 (NEW).]

B. The child's age and sex; [1979, c. 733, §18 (NEW).]

C. The nature and extent of abuse or neglect, including a description of injuries and any explanation given for them; [1979, c. 733, §18 (NEW).]

D. A description of sexual abuse or exploitation; [1979, c. 733, §18 (NEW).]

E. Family composition and evidence of prior abuse or neglect of the child or his siblings; [1979, c. 733, §18 (NEW).]

F. The source of the report, the person making the report, his occupation and where he can be contacted; [1979, c. 733, §18 (NEW).]

G. The actions taken by the reporting source, including a description of photographs or x rays taken; and [1979, c. 733, §18 (NEW).]

H. Any other information that the person making the report believes may be helpful. [1979, c. 733, §18 (NEW).]

SECTION HISTORY

1979, c. 733, §18 (NEW).

22 §4013. MANDATORY REPORTING TO MEDICAL EXAMINER FOR POSTMORTEM INVESTIGATION

(REPEALED)

SECTION HISTORY

1979, c. 733, §18 (NEW). 1983, c. 343, §2 (AMD). 2005, c. 373, §6 (RP).

22 §4014. IMMUNITY FROM LIABILITY

1. **Reporting and proceedings.** A person, including an agent of the department, participating in good faith in reporting under this subchapter or participating in a related child protection investigation or proceeding, including, but not limited to, a multidisciplinary team, out-of-home abuse investigating team or other investigating or treatment team, is immune from any criminal or civil liability for the act of reporting or participating in the investigation or proceeding. Good faith does not include instances when a false report is made and the person knows the report is false. Nothing in this section may be construed to bar criminal or civil action regarding perjury or regarding the abuse or neglect which led to a report, investigation or proceeding.

[1987, c. 395, Pt. A, §89 (AMD) .]

2. **Photographs and x rays.** A person participating in good faith in taking photographs or x rays under this subchapter is immune from civil liability for invasion of privacy that might otherwise result from these actions.

[1979, c. 733, §18 (NEW) .]

3. **Presumption of good faith.** In a proceeding regarding immunity from liability, there shall be a rebuttable presumption of good faith.

[1979, c. 733, §18 (NEW) .]

SECTION HISTORY

1979, c. 733, §18 (NEW). 1983, c. 783, §5 (AMD). 1987, c. 395, §A89 (AMD).

22 §4015. PRIVILEGED OR CONFIDENTIAL COMMUNICATIONS

The husband-wife and physician and psychotherapist-patient privileges under the Maine Rules of Evidence and the confidential quality of communication under Title 16, section 53-B; Title 20-A, sections 4008 and 6001, to the extent allowed by applicable federal law; Title 28-A, section 4228; Title 32, sections 1092-A and 7005; and Title 34-B, section 1207, are abrogated in relation to required reporting, cooperating with the department or a guardian ad litem in an investigation or other child protective activity or giving evidence in a child protection proceeding. Information released to the department pursuant to this section must be kept confidential and may not be disclosed by the department except as provided in section 4008. [2001, c. 696, §22 (AMD).]

Statements made to a licensed mental health professional in the course of counseling, therapy or evaluation where the privilege is abrogated under this section may not be used against the client in a criminal proceeding. Nothing in this section may limit any responsibilities of the professional pursuant to this Act. [2001, c. 696, §22 (AMD).]

SECTION HISTORY

1979, c. 733, §18 (NEW). 1981, c. 211, §1 (AMD). 1983, c. 781, §2 (AMD). 1985, c. 495, §21 (AMD). 2001, c. 696, §22 (AMD).

22 §4016. CONFIDENTIALITY OF EMPLOYEE RECORDS

Notwithstanding Title 5, section 554, subsection 2, paragraph E or any other provision of law, the confidentiality of employee records is abrogated in relation to required reporting, cooperating with the department or guardian ad litem in an investigation or other child protective activity or giving evidence in a child protective proceeding. [1983, c. 354, §4 (NEW).]

SECTION HISTORY

1983, c. 354, §4 (NEW).

22 §4017. DISCRIMINATION

No person may be discriminated against by any employer in any way for participating in good faith in reporting under this subchapter or in a related child protection investigation or proceeding. [1983, c. 354, §4 (NEW).]

SECTION HISTORY

1983, c. 354, §4 (NEW).

22 §4018. ABANDONED CHILD; SAFE HAVEN PROVIDER

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Medical services provider" means an individual certified, registered or licensed in the healing arts, including, but not limited to, a physician, nurse, podiatrist, optometrist, chiropractor, physical therapist, dentist, psychologist,

physician's assistant or emergency medical services person. [2001, c. 543, §2 (NEW).]

B. "Safe haven provider" means:

(1) A law enforcement officer;

(2) Staff at a medical emergency room;

(3) A medical services provider; or

(4) A hospital staff member at a hospital. [2001, c. 543, §2 (NEW).]

[2001, c. 543, §2 (NEW) .]

2. **Request for information.** A person who voluntarily delivers a child less than 31 days of age to a safe haven provider and who does not express an intent to return for the child may be requested to provide information helpful to the welfare of the child. The person who accepts a child under this section may not detain the person delivering the child to obtain information.

[2001, c. 543, §2 (NEW) .]

3. **Action by safe haven provider; guidelines.** A safe haven provider who accepts a child under this section shall promptly notify the department of the delivery of the child, transfer the child to the department at the earliest opportunity and provide to the department all information provided by the person delivering the child to the safe haven provider. The department shall establish guidelines to assist safe haven providers concerning procedures when a child is delivered to a safe haven provider under this section.

[2001, c. 543, §2 (NEW) .]

4. **Confidentiality.** All personally identifiable information provided by the person delivering the child to a safe haven provider is confidential and may not be disclosed by the safe haven provider to anyone except to the extent necessary to provide temporary custody of the child until the child is transferred to the department and except as otherwise provided by court order. All health care or other information obtained by a safe haven provider in providing temporary custody of the child may also be provided to the department upon request.

[2001, c. 543, §2 (NEW) .]

5. **Liability.** A person or entity who accepts a child under this section or provides temporary custody of a child accepted under this section is not subject to civil, criminal or administrative liability for accepting the child or providing temporary custody of the child in the good faith belief that the action is required or authorized by this section. This subsection does not affect liability for personal injury or wrongful death, including, but not limited to, injury resulting from medical malpractice.

[2001, c. 543, §2 (NEW) .]

SECTION HISTORY

2001, c. 543, §2 (NEW).

First Special Session of the 123rd Legislature, and is current through December 31, 2008, but is subject to change without notice. It is a version that has not been officially certified by the Secretary of State. Refer to the Maine Revised Statutes Annotated and supplements for certified text.

The Office of the Revisor of Statutes also requests that you send us one copy of any statutory publication you may produce. Our goal is not to restrict publishing activity, but to keep track of who is publishing what, to identify any needless duplication and to preserve the State's copyright rights.

****You can download the complete text at:

http://www. mainelegislature. org/legis/statutes/22/title22ch1071sec0. html

bhsi

BEHAVIORAL HEALTH SCIENCES INSTITUTE

2

Module 2 —

Working in a School Setting

Activities

Activity 1: *[Materials: embroidery thread, embroidery hoop, small dixie cups and marbles*]
Give each student one piece of embroidery thread and cup with 4 – 5 marbles in it.

Part 1

Ask the student to tie the ends of the embroidery thread together to form a circle (see diagram 1 and 2)

Diagram 1 – embroidery thread *Diagram 2 – thread tied to make a circle*

Ask the students to place the circle in front of them and *DUMP* their marbles into the circle. The marbles will roll all over the table, and some will fall on the floor. Some students will devise strategies for keeping the marbles in the circle. Ask the students to gather the marbles, put them back into the cups and then generate a class discussion about what happens when you have loose boundaries and different events push up against those boundaries. Questions you might ask:

- What happened when you poured your marbles into the circle?
- Where did you put your attention after you poured your marbles into the circle?
- What are some of the ways in which you might have loose boundaries?
- For those of you who kept some marbles in the circle, how did you do that?

Connect the answers to the importance of having strong boundaries.

Part 2

Place the embroidery hoop on a table in front of you. Take a cup of marbles (4 -5) and *DUMP* them inside the hoop, attempt to keep all of the marbles inside the hoop. Generate a class discussion on the difference between the embroidery hoop boundary and the embroidery thread boundary. Questions you might ask:

- What do you notice about this boundary?
- What was different about where you put your attention when the marbles were poured into the hoop?
- What are some of the ways to set and maintain strong boundaries?

What's the Point? To give the students a visual and experiential understanding of the importance of having strong professional boundaries

Activity 2:

Using a flip chart or white board, make two columns: 'Being Friendly' and 'Friend'; elicit from the class their ideas about the differences between being friendly vs. being a friend for each column.

Explore the following questions:

- What can a professional do that a friend cannot do?
- What can a friend do that a professional cannot do?
- What are some of the attitudes and/or behaviors that you find empowering?
- What are some of the attitudes and/or behaviors that cause you to feel dependent on another?

Connect the answers to the importance of empowering the child and family and avoiding creating dependency.

What's the Point? To support the students' learning of professionalism by giving them an opportunity to draw on their own experiences

Activity 3:

Have the following questions written on a flip chart and covered so the class cannot read them:

1. What medications do you take?
2. How many students were in your 2nd grade class?
3. What was your first sexual experience?
4. What illegal drugs have you used?
5. What are your religious beliefs?

Divide the class into groups of two. Ask one person to be the interviewer and one to be the interviewee. Unveil the questions and give the groups 2 – 3 minutes to respond to them. Reconvene the class and generate a class discussion by asking the students how it felt to ask and to be asked the questions. Questions you might ask are:

- How willing were you to answer/ask the questions? Why? Why not?
- How relevant do you think these questions are to the delivery of the service?
- What concerns did you have about being judged?

Compare this to how students might feel when they are receiving services that demand they reveal a significant amount of personal information.

What's the Point? To enhance the students' sensitivity to the experiences children have as recipients of behavioral health services.

Activity 4:

Give each student the Rate Your Stress handout. Allow 3-5 minutes for them to read and check off the current stressors in their lives and calculate their scores.

- Were you surprised by any of the items?
- What surprised you?
- Are there stressors that impact the child and family that should be added to the list?
- What score would you give the stressors? (looking for having a worker in your home, etc.)

What's the Point? To increase the students' awareness of the types and significance of stressors

Rate Your Stress

1. Read the following list
2. Put a check next to each event you experienced this year
3. Total the number following each item you checked
4. Find you Risk of Illness Score

___ Death of a spouse ***100***
___ Divorce ***73***
___ Marital separation ***65***
___ Jail term ***63***
___ Death of close family member ***63***
___ Personal injury or illness ***53***
___ Marriage ***50***
___ Fired from work ***47***
___ Marital reconciliation ***45***
___ Retirement ***45***
___ Change in family member's health ***45***
___ Pregnancy ***40***
___ Sexual difficulties ***39***
___ Addition to family ***39***
___ Change in financial status ***38***
___ Death of close friend ***37***
___ Change to a different line of work ***36***
___Change in number of marital arguments ***35***
___ Mortgage or loan over $10,000 ***31***
___ Foreclosure of mortgage or loan ***30***
___ Change in work responsibilities ***29***
___ Trouble with in-laws ***29***
___ Outstanding personal achievement ***28***
___ Spouse begins or stops work ***26***
___ Starting or finishing school ***26***
___ Change in living conditions ***25***
___ Revision of personal habits ***24***
___ Trouble with boss ***23***
___ Change in work hours or conditions ***20***
___ Change in residence ***20***
___ Change in school ***20***
___ Change in recreational habits ***20***
___ Change in church activities ***20***
___ Change in social activities ***20***
___ Mortgage or loan under $10,000 ***17***
___ Change in sleeping habits ***16***
___ Change in number of family gatherings ***15***
___ Change in eating habits ***15***
___ Vacation ***13***
___ Christmas season ***12***
___ Minor violations of the law ***11***

Your total score _____

Risk of Illness:
0 – 149 Low, 150 – 299 Moderate,
300 or above High

This scale shows the kind of life pressure you are facing. Depending on your coping skills this scale may indicate the likelihood that you might contract to a stress related illness.

Activity 5

Give each student a copy of the Burnout Quiz. Ask them to fill it out at home and reflect on their score.

Burnout Quiz

Assign a number from 1 (no or little change) to 5 (great deal of change)

_____1. Do you tire more easily? Feel fatigued rather than energetic?
_____2. Are people annoying you by telling you, "You don't look so good lately"
_____3. Are you working harder and harder and accomplishing less and less?
_____4. Are your increasingly cynical and disenchanted?
_____5. Are you often invaded by a sadness you can't explain?
_____6. Are you forgetting (appointments, deadlines, personal possessions)?
_____7. Are you increasingly irritable? More short-tempered? More disappointed in the people around you?
_____8. Are you seeing close friends and family members less frequently?
_____9. Are you too busy to do even routine things like make phone calls, read reports or send out holiday cards?
_____10. Are you suffering from physical complaints (aches, pains, headaches)?
_____11. Do you feel disoriented when the activity of the day comes to a halt?
_____12. Is joy elusive?
_____13. Are you unable to laugh at a joke about yourself?
_____14. Does sex seem like more trouble than it's worth?
_____15. Do you have very little to say to people?

_____ TOTAL

0-25 – fine and doing well
26-35 – there are things you should be watching
36-50 – you are a candidate for burnout
51-65 – you are burning out
>65 – you are in a dangerous situation, threatening to your physical and mental well-being

Don't let a high total alarm you, but pay attention to it. Burnout is reversible, no matter how far along it is. The sooner you start being kinder to yourself, the better.

What's the Point? To provide the students with a quick method for evaluating their risk of burnout

Activity 6:
Hand out and read The Goose Story.
Generate a class discussion that introduces topics related to team.

THE GOOSE STORY – Author Unknown
Next fall when you see geese heading south for the winter flying along in a "V" formation, you might be interested in knowing what science has discovered about why they fly that way. It has been learned that as each bird flaps its wings, it creates uplift for the bird immediately following. By flying in a "v" formation, the whole flock adds at least 71% greater flying range than if each bird flew on its own.

People who share common direction and sense of community can get where they are going quicker and easier because they are traveling on the thrust of one another.

Whenever a goose falls out of formation, it suddenly feels the drag and resistance of trying to go it alone and quickly gets back into formation to take advantage of the lifting power of the bird immediately in front. If we have as much sense as a goose, we will stay in formation with those who are headed the same way we are going.

When the lead goose gets tired, he rotates back in the wing and another goose flies point. It pays to take turns doing hard jobs.

The geese honk from behind to encourage those up front to keep up their speed. An encouraging word goes a long way.

Finally, when a goose gets sick or is wounded by a gun shot and falls out two geese fall out of formation and follow him down to help and protect him. They stay with him until he is either able to fly or until he is dead. They then launch out on their own or with another formation to catch up with the group.

If we have the sense of a goose, we will stand by each other like that.

bhsi

BEHAVIORAL HEALTH SCIENCES INSTITUTE

2

Module 2 —

Working in a School Setting

Content

Module 2 – Working in the School Setting

Overview

This module addresses the basic competencies necessary for working respectfully and effectively with a child in a school setting. Topics included in this module are setting and maintaining personal and professional boundaries, respecting privacy, sensitivity to cultural differences, dynamics of families who face multiple challenges, relaxation techniques, stress management and reduction, conflict resolution, and supervision.

Competencies

A. The participant will demonstrate an understanding of appropriate personal and professional boundaries.
(Level 1)

B. The participant will demonstrate an understanding of and sensitivity to differences in cultures, beliefs, and values.
(Level 1)

C. The participant will demonstrate an understanding of the dynamics involved in working with children of families who face multiple challenges. (Level 1)

D. The participant will demonstrate an understanding of relaxation techniques.
(Level 2)

E. The participant will demonstrate the ability to mediate and resolve conflict.
(Level 2)

F. The participant will demonstrate the ability to use and accept supervision.
(Level 2)

Competency

A The participant will demonstrate an understanding of appropriate personal and professional boundaries.

BOUNDARIES

A boundary is an invisible line between you and other people that sets the limits for how you interact with each other. Your comfort level with physical, emotional, intellectual, social, and spiritual expression defines your personal boundary. Your level of comfort is generally determined by how familiar you are with the person or situation. The specific boundary and how it is set is influenced by an individual's culture.

In general, a **physical** boundary is the way you use your body when you interact with another person. Some of the ways you establish a physical boundary around your body are by how far away you like to stand from another person or whether you give someone a handshake or allow someone to give you a hug. A physical boundary also includes a person's environment and belongings. Some of the ways you set physical boundaries around your environment and possessions are expecting people to ask before taking or sharing your items, like books, CDs or clothes.

Give three examples of things you do to establish your physical boundaries?

1. _____
2. _____
3. _____

A violation of physical boundaries can happen intentionally by forcing someone to have unwanted physical contact or unintentionally by simply standing too close to someone or making continuous eye contact.

Emotional boundaries are the ways you express your feelings and respond to another person's feelings. **Intellectual** boundaries are the ways you express your thoughts and ideas. **Social** boundaries are the rules and social etiquette you follow in your interactions with strangers, acquaintances, or friends. A **spiritual** boundary is the way you express your religious or spiritual beliefs.

Emotional, intellectual, social and spiritual boundaries can be violated when there is an expectation that a person should respond, behave, interact or believe in a way

that is outside of her/his comfort level. An emotional boundary violation can occur by demanding that a person express his/her feelings, inhibiting a person's expression of feelings, or judging a person's emotional expression. One of the ways an intellectual boundary can be violated is by expecting a person to learn new information by listening, when he/she actually learns by seeing. Failing to follow social etiquette can violate a social boundary, as can expecting more or less intimacy than the relationship would normally require. An example might be treating a new acquaintance as an intimate friend. Criticizing or devaluing someone's spiritual beliefs can violate a spiritual boundary.

What are things you do to establish your emotional, intellectual, and spiritual boundaries?

1. _____
2. _____
3. _____
4. _____

How do you establish social boundaries with:

1. (A stranger?) _____
2. (A friend?) _____
3. (A partner?) _____

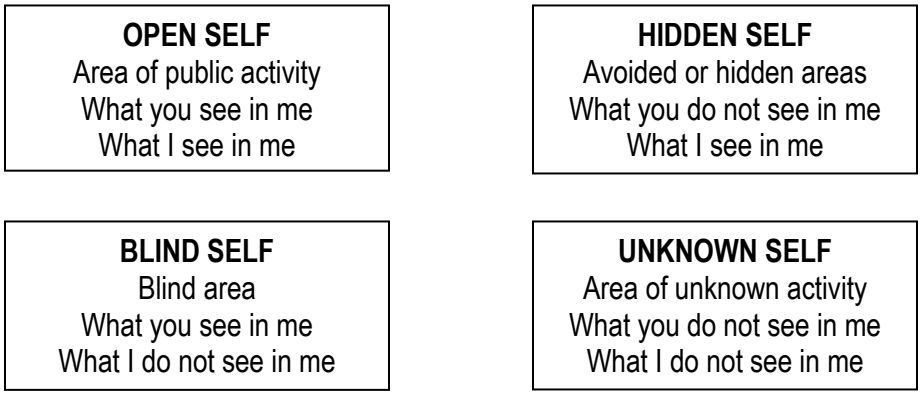
PROFESSIONAL BOUNDARIES

PROFESSIONALISM

Being a professional begins with you being aware of your thoughts, feelings, and actions. This is called self-awareness. Self-awareness is a skill that involves developing and mastering the use of an observing eye and ear. It is the ability to interact with another person and notice how you perceive the situations, and what you are doing or saying. Self-awareness also involves noticing your thoughts, feelings and actions when you are by yourself.

Being self-aware involves being interested in and curious about how you behave. It is being willing to uncover your unconscious motivations. It is understanding where your beliefs and values come from. It is knowing that there are things you do not see about yourself.

The Johari Window is a cognitive psychological tool created by Joseph Luft and Harry Ingham in 1969 as a way of visualizing self-awareness. It shows levels of self-awareness in four quadrants.



You should strive to be impeccably self-aware. You have impeccable self-awareness when you accurately understand your Open Self. You know what is appropriate and inappropriate to share of your Hidden Self. You are curious to learn about what others see in your Blind Self. You understand that there are some parts of yourself that you and others do not know about in your Unknown Self and you are willing to look at these unknown parts when they arise.

Think of how you present yourself to others and how others might see you. What are three adjectives you could use to describe how you think you appear to others?

1._____
2._____
3._____

For homework, ask someone who is familiar with you (family member, partner, or colleague) for three adjectives that would describe how you appear to him/her.

Strong professional boundaries will support you to be objective and to remain neutral. Being able to stay objective and neutral will help you to make accurate observations and to offer the child feedback about their communication styles, responses and interactions.

Your job description, school/agency policy, MaineCare Regulations and DHHS legal mandates define your professional boundaries. To establish this professional boundary, you will need to develop a professional persona.

PROFESSIONAL PERSONA

The manner in which you present yourself and the image that you project to the child is called your Professional Persona. One way you can develop a professional persona is to be knowledgeable, aware, confident and centered.

- Being knowledgeable means understanding and being able to explain the important aspects and functions related to your job, i.e.
    - Your job description
    - The school/agency policies and procedures
    - Your legal and regulatory responsibilities
    - Your role as a member of the IEP/treatment team
    - Your role in implementing the Individual Treatment Plan
    - Knowing the community in which the child and family live and resources that are available to them.

Using the bullets above, write a brief description of how these would apply to you.

_____

_____

_____

- Being aware means observing the things around you. It involves assessing issues that could affect the child. It also involves being sensitive to what impact you may be having on the child. Some of the things you will want to be observing and documenting are:
    - Safety concerns (yours, the child's, etc.)
    - Unmet needs (food, clothing, medical, etc.)
    - Informal/formal observations and measurements of the child's progress
    - Your consistency and dependability (being on time, following through, keeping promises, following the ITP)
    - Promoting a safe and secure environment
    - Building trust

- Being confident means being self-assured, positive and self-reliant. It involves showing the child that you will work with them to bring about positive change. Confidence does not mean having all the answers, but it does involve being able to say "I don't know, but I will find out." Being confident can:
    - Instill hope
    - Promote a safe and secure environment
    - Build trust

- Being centered means recognizing the physical sensation of having your feet firmly planted on the ground and a healthy emotional detachment. There are a number of ways in which you can be knocked off your center in your work. They are:
    - Someone presses one of your 'hot buttons'
    - Someone challenges a strongly held belief
    - Your stress level gets too high
    - You experience a strong emotional reaction (fear, anger, sadness)
    - You feel under the weather
    - You become emotionally involved
    - You are distracted by an issue or event outside of work

Because you are consciously using yourself in your work as a SB-BHP it is very important that you take good care of yourself. Having strong boundaries is an essential part of taking care of yourself. Good supervision is important in the development and maintenance of a healthy professional persona. It is also essential to have a support system both at work and in your personal life.

Some of the common sense ways you can establish **professional** boundaries are:

- Understand your role
- Be dependable and consistent
  Show up on time…leave on time
  Mean what you say and say what you mean'
- Be a positive role model
  Act in the manner you want the child to act. Convey hope
- Understand the ITP and supporting documents
  If it is not on the ITP do not do it
- Clarify expectations, re-set boundaries
  Check in often with the child to make sure you are on the same page
- Be thoughtful about personal disclosure
  Use your talents and personal experiences wisely and for the benefit of the child

CONSCIOUS USE OF SELF

You will be using your life experiences, imagination, creativity, values, and beliefs in your work with the child. Using your experiences and expertise for the professional benefit of another is the *conscious use of self.* It will be very important to be thoughtful and purposeful about sharing personal information. A good practice is to use supervision to discuss what kinds of personal information would

be appropriate to share. Questions you might ask yourself when you feel like you want to share some personal information are:

- Who will benefit from what I want to share?
- What do I hope to get by sharing the information?
- If I share the information, will it violate a boundary?

WORKING ALLIANCE

The working alliance is the nature of your relationship with the child. The focus of this relationship is to help the child achieve his/her goals. Healthy and strong professional boundaries are essential building blocks of a working alliance. Your professional boundaries will help you to establish and build trust. They will keep you grounded in what is in the best interest of the child. Instilling hope is another aspect of the working alliance. Encouragement, understanding, recognizing strengths and normalizing the child's struggle are all things you can do to instill hope.

BOUNDARY VIOLATIONS

A boundary violation occurs when the stated or unstated rules or expectations in a relationship are broken. All relationships have times when someone's boundary is violated. This is often an unintentional act. In general, there are two types of boundary violations that occur when providing support services.

- The child infringes upon the SB-BHP's professional or personal boundary. An example might include a student looking up the SB-BHP's home phone number and calling her/him at home.

- The SB-BHP crosses his/her professional boundary. An example might be the SB-BHP giving the client a birthday present.

WARNING SIGNS

Often times there are warning signs that the professional boundary is in danger of being crossed. Familiarity with these warning signs will help you avoid a violation or respond in a timely manner when one occurs. Some of the warning signs include, but are not limited to:

- You are asked to do something that is not on the ITP
- There is a change in the child or parent's attitude toward you
- You are invited to a family social event
- A family member engages you in a personal conversation or asks personal information
- You are asked to keep a secret

- You begin to feel that you are the only one who understands the child
- You withhold information from your supervisor
- You give or receive a gift

MINIMIZING BOUNDARY VIOLATION

Even when you have the best of intentions and make the best efforts to function within the limits of your professional relationship, a boundary violation can occur. Incorporating the following strategies into your day-to-day work may help to reduce the likelihood of a boundary violation.

- Adhere to school/agency policy and procedure and follow the ITP.
- When in doubt, say you don't know and will find out.
- Make sure the time you spend with the child is scheduled and/or approved.
- Avoid doing 'favors'.
- Be willing to constantly define and redefine your role.
- Develop and refine observation skills for self and other.
- Use supervision to explore your reactions to the child.

THE BIG PICTURE

You are a member of a team, which can include the following: the child and family as the team leaders, clinical staff, teachers, service providers, school administration, case manager, community resources, and medical and rehabilitation professionals. Everyone on the IEP/treatment team should know who you are, what your role is, and that the ITP guides the work that you do with the student.

The establishment of your personal and professional boundaries will be an ongoing process. In your initial interaction with the child you should clearly define your role. You will be friendly, but you are **not** a friend. There will be many times when you will role model clear personal and professional boundaries for the child. You will help the child define their personal boundaries. A general rule for role modeling is to "practice what you preach". Behave in ways you expect the child to behave - demonstrate positive and respectful behaviors. Review and clarify roles as often as necessary to maintain clear professional and personal boundaries. Repetition is a useful strategy.

Read the following scenario and define the boundary violation.

You have been working with Deb, a nine-year-old girl with autism, for six (6) months. You have been working on increasing Deb's social skills. Deb also has a speech and language therapist to help her with her verbal skills. There has been a

significant improvement in her verbal skills. One day at school, Deb comes into the room and hands you an invitation to her 10th birthday party on Saturday. She then tells you how much she wants you to come to her party, so that you can meet her grandmother and her dog Lucy. You don't want to disappoint Deb, so you agree to come.

- Which boundary has been violated?
- How could be done to re-establish this boundary?
- What should you have done?

Competency

B The participant will demonstrate an understanding of and sensitivity to differences in cultures, beliefs, and values. (Level 1)

CULTURAL COMPETENCE

The *Center for Effective Collaboration and Practice* defines cultural competency as "a set of congruent behaviors, attitudes and policies that come together in a system, school/agency or among professionals and enable that system, school/agency or those professionals to work effectively in cross-cultural situations." There are five (5) elements that contribute to cultural competence:

- Accepting and respecting differences
- Understanding how one's actions can affect people from other cultures
- Awareness of factors effecting cross-cultural interactions
- Adding knowledge gained through cross-cultural interactions to ongoing practice
- Changing practice methods and activities to fit cultural norms

FAMILY CULTURE

Every family has its own unique culture. The family's race, ethnicity and religion will contribute to its culture. There are also many other factors that shape a family's culture. These include, but are not limited to:

- The physical setting; for example, how the shared space or private space is viewed
- The neighborhood
- Level of income
- Family history
- Family expectations; for example, what each person should achieve or how to behave inside and outside of the family home
- Family roles; for example, specific functions of the father or mother or extended family

Some of the ways that family members behave can be understood as being unconscious and the purpose of their behaviors is to maintain the family culture

and stability. These roles can range from being flexible and interchangeable to rigid and oppressive. A few of these might include:

- The Scapegoat – this is the person who is seen as the 'problem'
- The Hero – this is the person who is expected to do well and receive the family's praise
- The Servant – this is the person who pays attention to everyone's needs
- The Dictator – this is the person who makes and enforces all the rules for the family
- The Clown – this is the person who usually diffuses tension by being playful or joking

Other factors that influence the family culture are:

- The expectations of how boys and men and girls and women are supposed to behave
- The manner in which the extended family and different generations interact

Understanding these cultural dynamics and/or the role that the child plays, can assist the SB-BHP in achieving an appropriate perspective on behaviors that may occur at school and which may be influenced by these factors.

DEVELOPING YOUR CULTURAL COMPETENCE

Every family is different. You will notice things that you have in common with the child you work with, and you will also notice ways in which you are very different. One of your challenges will be to seek an understanding where there are differences, uncertainties, and what seem to be unacceptable behaviors. You will need to develop an attitude of **Unconditional Positive Regard**. This means you perceive the child in a positive, non-judgmental, and accepting manner. The person is separated from the behavior; the child does not have to prove he/she is worthy of your respect and compassion. Being curious and listening to the child will help you to develop unconditional positive regard. You will find that the more you understand about the child, the more you will respect them and can offer support and empathy.

You can demonstrate respect for the child by demonstrating an understanding attitude. Seeking to understand the child first, instead of expecting them to understand you, is an effective strategy for setting a professional boundary, understanding behaviors and managing a challenging situation. The ability to listen and observe will be essential skills to master. Gathering information about the

strengths and interests of the child will help you to better understand them. It will also give you tools for helping them work toward their goals.

You can also demonstrate respect for the child by acknowledging that change can be difficult and offering encouragement and support. Making positive and caring comments can show the child that you believe they can meet their goals. Your positive thinking and hope is contagious and can help keep the child motivated as they work on developing new skills.

Most likely there will be times when you will find it hard to be respectful and when being curious and open to different cultures seems impossible. You will need to develop strategies to handle these types of situations. Some of the things that you can do to build your cultural competency are:

- Gain a clear understanding of your own culture, including strongly held values and beliefs
- Seek to understand how your culture could affect the child
- Recognize that there are many different ways of seeing the world and accomplishing the tasks of daily living
- Identify ways you can support cross-cultural interactions
- Seek to understand the purpose or function of different aspects of the child's culture
- Recognize that acceptance of another culture does not mean you abandon your own culture
- Make learning about other racial, ethnic and religious cultures a part of your life-long learning

Briefly describe your family culture. What are some of the strongly held values and beliefs in your family?

Competency

C The participant will demonstrate an understanding of the dynamics involved in working with children of families who face multiple challenges. (Level 1)

MULTIPLE CHALLENGES

Families who have a child or children with a disability face many challenges and stresses. The challenges and stresses that a family will experience will be unique. You should have a general understanding of some of these challenges, and the effect that these challenges may have on the children you work with.

The **Grief Process** is a normal experience for families who have a child with a disability. The stages of grief are denial, anger, bargaining, depression and acceptance. Each member in the family will have a unique experience of grief and will move through the process in his/her own unique way. In the course of your work you may, for instance, encounter cases where one parent is in a denial phase, while the other parent is in the anger phase. Or they might be experiencing a new loss altogether as they see their child move from one developmental stage to another. For example: One of the father's dreams was to watch his child play in Little League and now the child's peers are joining Little League teams. The father realizes that because of his child's disability he will not be watching his child play baseball. For many parents this is experienced as a new loss, and they will begin the grieving process again.

The demands of caring for a child with a disability can create significant stress. For many, the stress becomes chronic. **Chronic Stress** happens when a person experiences constant demands and pressure for a long time without any relief. Some of the symptoms of chronic stress are fatigue, frequent colds, feelings of hopelessness and poor coping skills. Factors that can contribute to chronic stress include, but are not limited to, the following:

- Day-to-day demands and disruption in routine
- Inadequate resources, or lack thereof, such as financial, medical, or respite help
- Being overwhelmed by the requirements for accessing resources
- Having behavior patterns that leave the person ineffective in identifying and reducing stress in their own lives
- Being unable to pursue social and recreational interests, which can affect the child's ability to replenish his/her energy supply

Individuals will respond in their own unique ways to the stress in their lives. Some may respond with:

- Resistance to change – You may find that the child is resistant to change. This is normal. There are many reasons for a child and family to resist change. Change is difficult and requires a great deal of energy. Often there is a motivation to change, but the outcome of change is unknown. The familiar feels safe and the unknown feels scary.
- Withdrawal – The child and/or the family are usually exhausted. Years of struggle and frustration can erode their inventiveness and creativity. They may not have the energy to pursue social and recreational activities. Friends and family may have also withdrawn leaving the child and/or family to survive on its own.
- Rigidified functioning – Children and/or families who are stressed will use whatever works to survive. They may be using behaviors that are not meeting their needs, and which may actually be contributing to their problems. They may have a fear of letting go of what they are doing and of learning new concepts and approaches.

Adult Disabilities

In some families a parent or parents may be coping with their own disability. It could be a **Mental Illness** or **Mental Retardation** or a **Physical Illness**. In these situations, the parent(s) is faced with the stress of raising a child with a disability and the stress of coping with their own illness. This can have a significant effect on the parent(s) resources.

A parent with a mental illness may feel overwhelmed with insecurity or poor self-esteem. S/he may have fears of losing her/his child because s/he thinks s/he is being seen as an inadequate parent.

A parent with mental retardation may feel frustrated with learning new skills or understanding how to meet the child's needs. S/he may also worry about losing her/his child.

A parent with a physical disability may worry about having the energy to meet the child's needs or might be preoccupied or distracted by his/her own illness. S/he may also be concerned about what will happen to the child if s/he can no longer care for her/him.

These families may also have limited financial resources. They might have difficulty paying for medications or providing the family with three square meals or paying for utilities. They may not be able to access resources because they don't

have transportation or a telephone. They may not have a support network and instead be isolated from extended family and friends.

Poverty
Sometimes the child's disability interferes with the parent(s) being able to work full time. Some parents are unable to maintain a full time job and the family may end up living in poverty. Living at or below the poverty level creates stress. When a family is struggling to meet basic needs, they may find that they have very little energy for anything else.

Alcohol and/or **Drug Abuse** and **Domestic Violence** are complex issues that can affect a parent(s) at the same time the stress is taking its toll on his/her ability to cope. A parent(s) may use alcohol or drugs to numb out from the stress, or she/he might strike out in frustration or as a means to control a situation.

You need to be aware of the range of challenges a child and his/her family may face. As a SB-BHP, you may work with a child whose family has one or more of these challenges. These challenges are complex. You will have many feelings about the parent(s) and the things they are facing. You may feel great empathy and sympathy for the family and want to 'fix' it for them or you may feel like you know how the parent(s) should solve their challenges. You may feel angry at the parent(s) or you may feel like you want to protect the child from the parent(s). Whatever the feelings, when they do come up, you must remember your professional boundaries. You should discuss your feelings with your supervisor so that you can do the best thing for the situation. Your ability to simply observe the facts and report them back to the team will enable the team, which includes the parent(s), to develop a plan for coping with the challenges.

What effect(s) might these challenges have on a child?

Competency

D The participant will demonstrate an understanding of relaxation techniques. (Level 2)

STRESS AND STRESS REDUCTION TECHNIQUES

Stress is a normal part of everyday life. Being able to cope with stress is a hallmark of healthy functioning. Children with disabilities may feel stressed or frustrated coping with their disability. There are many different causes for a child's stress or frustration. It could be caused by something related to his/her learning or communication style or sensory responses. For example, a child may be a visual learner and have difficulty in understanding verbal instructions or a child may need a full 30 seconds to process verbal directions. It could be related to autism, developmental delays, or another mental health diagnosis. It could be related to environmental factors. The same characteristics that affect a child's stress level may also affect his/her ability to develop effective coping skills.

Children may not be able to verbally express their feelings, but they will probably be able to show their stress and frustration through their behaviors. The child may be impulsive or quick to show how s/he is feeling with her/his behavior. Many students will have some type of goal or strategy in their ITPs for teaching self-control and/or to help increase his/her ability to cope with their feelings. One of the building blocks to self-control is having the ability to relax and to reduce stress.

STRESS REDUCTION STRATEGIES

You will be helping the child to develop new ways to cope with the day-to-day stress and long-term stressors. The following are strategies that a child can use to cope with stress on a daily basis and ways to make stress reduction a part of his/her routine:

Managing Day-to-Day Stress

- Stop, Look, and Listen – identify the source of the stress
- Take a 5 minute break
- Drink a glass of water
- Make a plan
- Breathe deeply, count to ten, breathe deeply, count to ten, etc.

BURNOUT

A person who is 'burnt out' feels physically and emotionally exhausted. It happens when someone experiences persistent stress and can't get relief. Often s/he is not aware that what s/he is experiencing is burnout.

As a role model for the child you will want to have healthy ways to cope with your stress. If you experience persistent stress in your job, you will run the risk of physical and emotional exhaustion, or burnout. Some of the symptoms are:

- Emotional – low energy, irritability, difficulty thinking or can't slow down
- Physical – change in sleep and appetite, change in weight or vulnerability to getting colds or the flu
- Loss of a sense of accomplishment
- Depersonalization – distancing from the child, talking about the child as a diagnosis, being negative and judgmental

There are several things that can cause burnout:

- Lack of supervision
- Lack of administrative support
- Working harder than the child
- Using work to meet your personal needs (for acceptance of being liked or feeling important)
- When your skills don't match what you are expected to do. If you have a lot of skill and are asked to do very little, you can get bored. If you don't have the skills to do what is expected of you, you can get overwhelmed

Strategies you can use to avoid burnout are:

- Be aware of the symptoms
- Use supervision to talk about how you are feeling about the work
- Have realistic expectations
- Build a sense of competency, make sure your skills and the job expectations are a match
- Maintain a healthy lifestyle (diet, exercise, recreation, quiet time)
- Keep strong, healthy professional boundaries
- Get support from your colleagues
- Use strategies to cope with day-to-day stress

RELAXATION STRATEGIES

You will want to learn several different relaxation strategies that you can use for yourself and also teach the child. Some of the strategies that you might learn are:

- Deep breathing exercises
- Progressive relaxation
- Guided imagery
- Mindfulness
- Meditation
- Physical exercises

Coping Strategies for the child:

- Listening to soothing music
- Going for a walk
- Putting a puzzle together
- Being read to
- Playing a game
- Coloring or drawing or writing
- Sitting in a dimly lit room

What other things might a child do to relax?

1. _____
2. _____
3. _____
4. _____
5. _____

Competency

E The participant will demonstrate the ability to mediate and resolve conflict. (Level 2)

CONFLICT MANAGEMENT

Conflict is a normal part of all human relationships. Conflict can arise in many different ways. Sometimes it is simply a miscommunication, a different point of view, different belief, or wanting something different. A simple way to put it is that a conflict happens when a person feels that s/he is, or was about to be, negatively affected by another person. Conflicts usually fall into one of the following four (3) categories:

- Goal – goals that are incompatible can be seen as threatening
- Judgment – the facts are perceived differently
- Normative – one person says how the other should behave

In general, there are five (5) ways that people deal with conflict. There is no one correct way to handle a conflict. You can become very effective at conflict resolution by being able to use a variety of conflict resolution strategies. The five (5) strategies for resolving conflict are:

- Avoiding
- Accommodating
- Competing
- Compromising
- Collaborating

Your role in resolving conflict is to facilitate a conversation that will help the people who are having the conflict to find a way to resolve it. A successful negotiation can prevent a situation from escalating into a crisis. The aim is to reach a mutually agreed upon resolution by using a win-win approach. You will be role modeling and teaching valuable skills, such as assertiveness, self-control, acceptable social behavior, and building relationships. Successful conflict resolution takes time, willingness, and commitment.

The elements of conflict resolution can be broken down into two categories, providing a safe environment and acknowledging underlying feelings and values.

Steps to creating a safe environment are:

- Make sure each person is in control of his/her feelings and wants to participate
- Assure each person involved that s/he will have the opportunity to express her/his views
- Pick a place that is safe for everyone involved and where you will not be interrupted
- Get everyone involved to agree to stay and work out the differences

Steps to acknowledging feelings and values are:

- Listen carefully to what is said; notice how the person may be feeling
- Repeat or summarize each person's statement of the problem and the feeling that is being expressed
- Support each person to speak without interruption
- Allow for safe venting of feelings in a non-abusive manner
- Teach by example; when you are involved in the conflict, role model taking responsibility for your part in the conflict

There may be many situations in which the best way to resolve the conflict is to collaborate. There are four (4) parts to the collaborative problem solving process.

1. Define the conflict.
    - Reconstruct and examine the events leading to the conflict from each person's point of view.
    - Help each person to say what s/he thinks and feels, wants and needs.
    - Check in with each person to make sure you understand his/her point of view. This also helps each person to clearly understand the other's point of view.

2. List alternative solutions.
    - Brainstorm possibilities without evaluating them. Write them down.
    - Have each person imagine what he/she would like the result to be. Write them down.

3. Choose the best solution(s).
    - Select the best solution that everyone agrees is fair and feels safe and comfortable.

- Help each person to identify what he/she can and cannot agree to. Write down what is agreed to.

4. Evaluate the results.
   - Describe how each person will know when the solution has worked.
   - Plan a time to review how the solution is working.

The following are some questions you might ask during the conflict resolution process:

- What is going on?
- How did it happen?
- How does it affect you?
- How does it affect the other person or the situation?
- What do you want or need?
- What does the other person want or need?
- How will you get it?
- What will you give? How will you give it?
- Is there room to compromise?
- What might happen?
- What do you want to happen?
- Where do you start?
- When do you start?
- How will you know it worked?
- How will the other person know it worked?
- When do you want to review the solution?

A helpful way to think about conflict is that it is an opportunity to learn and grow. The SB-BHP is teaching skills when resolving a conflict. Some of the things to keep in mind that can support a child during the process are:

- Focus on supporting positive self-esteem
- Focus on building relationship skills (empathizing, apologizing, fairness)
- Teach self-control and pro-social behaviors
- Teach problem solving and conflict management skills
- Empower the child to take responsibility

There may be situations in which going through the conflict resolution process is not possible. You can help to reduce the tension around the conflict by:

- Keeping a respectful attitude
- Trying to understand each point of view

- Using a win-win approach
- Being curious about what is happening – asking questions
- Looking for ways to create a solution

You will experience a wide range of situations in which conflict management will be required. Sometimes you will be mediating a conflict between two individuals. There may be other situations in which the conflict is between you and someone else. Or there could be conflict among members of the IEP/treatment team. Regardless of the situation, your aim should be to reduce the tension and support finding a solution. You should discuss all the conflicts that arise with you supervisor. Having thoughtful discussions about the conflict, your feelings about it and responses to it will help you master conflict resolution.

Exercise:
Recall a conflict you have had or are having with a friend, member of your family, or colleague. Describe how you would resolve the conflict.

Competency

F The participant will demonstrate the ability to use and accept supervision. (Level 2)

SUPERVISION

The Merriam – Webster Collegiate Dictionary defines supervision as "the action, process or occupation of supervising; *especially*: a critical watching and directing (as of activities or a course of action). Generally speaking, there are four (4) types of supervision:

- Administrative – The focus is on addressing tasks related to meeting specific job expectations, such as progress notes and dealing with issues such as scheduling, vacation time or benefits.
- Individual – This is a one-on-one meeting with the supervisor that focuses on issues related to the delivery of the service.
- Group – This is a meeting of SB-BHPs in which the supervisor sets an agenda and facilitates discussion of issues related to the delivery of the service.
- Peer – This is a meeting of SB-BHPs that discusses issues related to their work and offers each other support. A supervisor may or may not be present at peer supervision.

The Child Welfare League of America's standard for supervision, as put forth in their Standards of Excellence for Services to Strength and Preserve Families with Children, is "All family-centered program staff members should receive formal case consultation at least once a week".

Supervision requirements are outlined in the DHHS Mental Health Licensing Rules and in school/agency's contracts with DHHS-CBHS. Mental Health Licensing requires the SB-BHP to have four (4) hours of supervision per month. A SB-BHP working under MaineCare Section 24 will follow the guidelines for supervision that are in the school/agency's contract with DHHS-CBHS.

The role of the supervisor is to provide you with a clear and concise job description. S/he will guide and support you as you establish a working relationship with the child and family. S/he will help you develop unconditional positive regard for the child and family. Supervision should provide a safe place

for you to talk about your reactions and responses. You supervisor can help you develop effect self-awareness skills. S/he will review your interactions with the child and family and problem solve with you regarding issues or concerns related to your work. S/he will help you understand how the child affects you and how you might be affecting the child. Individual supervision should be a time when you can freely express your thoughts and feelings about your work with the child.

The supervisor will oversee the development, coordination, and review of the ITP. S/he will give you instructions on the implementation of the ITP.
The supervisor should also keep you informed about changes in school/agency policy or procedure, internal or external training opportunities, and other information related to your job.

THE ROLE OF THE SB-BHP IN SUPERVISION

Your role as a SB-BHP in supervision is to keep your supervisor informed about all the activities and observations related to working with the child. You provide the IEP/treatment team with important observations about the effectiveness of the ITP. Your objective (the facts) and subjective (your feelings/thoughts) observations provide the IEP/treatment team with invaluable information for the ongoing assessment of the IEP/treatment plans.
You need to be self-aware. Self-awareness will help you understand your interactions with the child. Self-awareness involves knowing when your "buttons are being pushed" – when you are reacting instead of intentionally responding to the child or parent. It helps you learn about what the child does (unintentionally or intentionally) to "push your buttons". Being self-aware also involves being aware of your strengths and weaknesses. Developing clear awareness about your thoughts, feelings and reactions can help you to manage your stress. It is important to talk with your supervisor about the emotions you feel as you work with the child and to become clear about what affects you and how you are affecting others.

The supervisor will help you to understand your emotions and responses and develop effective strategies for diffusing stressful situations. S/he will also work with you to clarify your strengths and weaknesses and enhance your skills. One goal of this supervision is to help you maintain an attitude of unconditional positive regard for the child. Supervision is also a time to ask questions and explore strategies for implementing the ITP.

Exercise:
Tom is a 10-year-old boy with a diagnosis of oppositional defiant disorder, obsessive compulsive disorder, and an anxiety disorder NOS. You have been working with Tom as a 1 on 1 for two months. The ITP objective is for Tom to reduce his oppositional behavior and follow directions with no more than 3 cues and without needing a time out. Nothing is working. You are frustrated and having difficulty using unconditional positive regard. You are beginning to think this kid is just too difficult. You have requested a meeting with your supervisor. How will you prepare for the meeting? What are you hoping your supervisor will do?

bhsi

BEHAVIORAL HEALTH SCIENCES INSTITUTE

3

Module 3 —

Typical Child Development

Activities

Activity 1: Case Presentation

In groups of 3 or 4, or individually, ask the students to prepare a written case summary on a child they are working with or have worked with. Give them the following questions to help them organize the summary. Allow 30 – 45 minutes for in class preparation. When the summaries are completed, have the group or individual present the case summary to the class. Encourage the class to ask questions. For each case presented, add to the content by deepening the discussion about the normal developmental phase and the diagnosis of the child presented. The cases presented should cover several different developmental stages and diagnosis.

- Age (months and year), gender, and diagnosis of the child
- Describe the things you like about the child.
- Identify the development stage and describe the physical, psychosocial and cognitive abilities.
- Identify the areas in which the child excels.
- What are the child's interests/passions?
- Identify the child's diagnosis. What are the symptoms that the child exhibits?
- What are the circumstances when the symptoms are not present?
- What are the circumstances when the symptoms are most noticeable?
- Does medication help to alleviate some of the symptoms? If so, what is the medication and what are the symptoms it addresses?
- What are some of the interventions that are typically used with this diagnosis?
- How do these interventions build on the child's strengths?
- What do you expect the child to be able to do when s/he is ready to be discharged?

What's the Point? To give the students the opportunity to develop a case summary and present it to

the class; it also gives the instructor an interactive strategy for teaching normal child development and child pathology

bhsi

BEHAVIORAL HEALTH SCIENCES INSTITUTE

3

Module 3 —

Typical Child Development

Content

Module 3 — Typical Child Development & Pathology*

Overview

This module serves as an introduction to the typical developmental milestones of children. It also introduces mental health diagnoses of children that are commonly encountered by the SB-BHP. It includes strategies likely to be found in the Individual Treatment Plan, and the role of medications. This module also gives a strategy for formulating a case summary.

Competencies

A The participant will demonstrate knowledge of mental health disorders of childhood, including diagnoses commonly encountered in working with children in school settings.
(Level 1)

B The participant will demonstrate understanding of the role of medications in the treatment of mental health disorders.
(Level 1)

C The participant will demonstrate the ability to formulate a case summary.
(Level 1)

*** NOTE TO THE SB-BHP:** The intent of this module is to give you a very general understanding of typical child and family development and brief overview of mental health disorders of childhood. It will also provide you with a list of resources to use when you need to gather information about a child's developmental stage and diagnoses.

Competency

A The participant will demonstrate knowledge of mental health disorders of childhood, including diagnoses commonly encountered in working with children in the school setting.
(Level 1)

MENTAL HEALTH

There are many different definitions of mental health, which can be summarized as how a person feels, thinks, and acts. Mental health is seen in how a person treats him/herself and others, responds to stress and how s/he makes decisions.

CAUSES OF MENTAL ILLNESS

Our understanding of mental illness comes from research in behavioral and neuroscience. Environmental, biological, or a combination of both factors can influence mental health problems. The following risk factors have been identified as possibly contributing to the development of a mental health disorder:

- Prenatal exposure to alcohol, illegal drugs, tobacco
- Low birth weight
- Difficult temperament (high level of activity, inability to attend, negative mood)
- Inherited predisposition to a mental illness
- Environmental problems (poverty, deprivation, abuse, neglect)
- Unsatisfactory relationships
- Parental mental illness
- Exposure to traumatic events

A diagnosis of a mental illness is made when the symptoms are so severe that they impact the person's ability to function in school or work, emotionally and/or socially. According to the National Institute of Mental Health (NIMH), 1 in 10 children or adolescents may have a serious mental health problem.

DIAGNOSIS

A mental health diagnosis is made by a licensed clinician who formulates the diagnosis. The licensed clinician could be a psychiatrist (MD), psychologist (Ph.D.), clinical social worker (LCSW), licensed professional counselor (LCPC), or psychiatric nurse (RNC). The diagnosis is made after the clinician conducts an

assessment. The assessment usually involves interviews with the parents and/or child and may include psychological testing.

The child you work with will have a diagnosis that is defined in the Diagnostic and Statistical Manual of Mental Health Disorders IV (DSM-IV) or in the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R). More and more diagnosing practitioners use the DC: 0-3R manual as a compliment to the DSM-IV for diagnosing children three years of age and under. Both manuals use a multi-axial classification system.

	DSM IV	DC: 0-3R
Axis I	Clinical Disorders	Clinical Disorders
Axis II	Mental Retardation or Personality Disorders	Relationship Classification
Axis III	General Medical Conditions	Medical and Developmental Disorders and Conditions
Axis IV	Psychosocial and Environmental Problems	Psychosocial Stressors
Axis V	Global Assessment of Functioning	Emotional and Social Functioning

There are some disorders that are difficult to diagnose. Sometimes the symptoms a child presents are common to several different disorders. In cases where the diagnosis is unclear, a "deferred" or "provisional" diagnosis is made. In cases where there is not a clear diagnosis, your objective observations of the child's behavior will be important in helping the clinician formulate a diagnosis.

It is important to keep in mind that the "diagnosis" is a *part* of the person and not the *whole* person. It is useful in identifying the symptoms and behaviors that are impacting the child's functioning. The diagnosis is a tool that the clinician/supervisor uses to identify the problem or areas of need, the goals and objectives for the ITP.

What is the diagnosis of a child you work with? Describe the child's symptoms. Identify a treatment goal that addresses one of the child's symptoms. Describe the objective and interventions you would use.

LISTING OF DSM IV CLASSIFICATION – AXIS I

Attention-Deficit and Disruptive Behavior Disorders

- **ATTENTION-DEFICIT/HYPERACTIVITY DISORDER**
  - Combined Type
  - Predominantly Inattentive Type
  - Predominantly Hyperactive-Impulsive Type
- Attention-Deficit/Hyperactivity Disorder NOS (Not Otherwise Specified)
- Conduct Disorder
- Oppositional Defiant Disorder
- Disruptive Behavior Disorder NOS

Mood Disorders
Depressive Disorders

- Major Depressive Disorder
  - Single Episode
  - Recurrent
- Dysthymic Disorder
- Depressive Disorder NOS

Bipolar Disorders

- Bipolar I Disorder
  - Single Episode or

Most Recent Episode (mixed, hypomanic, manic, depressed)

- Bipolar II Disorder
- Hypomanic/Depressed
- Cyclothymic Disorder
- Bipolar Disorder NOS

- Mood Disorder Due to
  General Medication Condition
  Substance-Induced Mood Disorder
- Mood Disorder NOS

Anxiety Disorders

- Panic Disorder without Agoraphobia
- Panic Disorder with Agoraphobia
- Agoraphobia without history of Panic Disorder
- Specific Phobia
- Social Phobia
- Obsessive-Compulsive Disorder
- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Generalized Anxiety Disorder
- Anxiety Disorder due to
  General Medication Condition
  Substance-Induced Anxiety Disorder
- Anxiety Disorder NOS

Learning Disorders

- Reading Disorder
- Mathematics Disorder
- Disorder of Written Expression
- Learning Disorder NOS

Motor Skills Disorder

- Developmental Coordination Disorder

Communication Disorders

- Expressive Language Disorder
- Mixed Receptive-Expressive Disorder
- Phonological Disorder
- Stuttering
- Communication Disorder NOS

Pervasive Developmental Disorders

- Autistic Disorder
- Rett's Disorder
- Childhood Disintegrative Disorder
- Asperger's Disorder
- Pervasive Developmental Disorder NOS

Schizophrenic and Other Psychotic Disorders

- Schizophrenia
  - Paranoid Type
  - Disorganized Type
  - Catatonic Type
  - Undifferentiated Type
  - Residual Type
- Schizophreniform Disorder
- Schizoaffective Disorder
- Delusional Disorder
- Brief Psychotic Disorder
- Shared Psychotic Disorder
- Psychotic Disorder due to
  - General Medication Condition
  - Substance-Induced Psychotic Disorder
- Psychotic Disorder NOS

Substance-Related Disorders (abbreviated)

- Alcohol-Related Disorders
- Alcohol Use Disorder
  - Alcohol Dependence
  - Alcohol Abuse

- Alcohol-Induced Disorders
- Amphetamine (or Amphetamine-like)-Related Disorders
- Amphetamine-Induced Disorders
- Caffeine-Related Disorders
- Cannabis-Related Disorders
- Cocaine-Related Disorders
- Hallucinogen-Related Disorders
- Inhalant-Related Disorders
- Nicotine-Related Disorders
- Opioid-Related Disorders
- Phencyclidine (or Phencyclidine-like)-Related Disorders
- Sedative, Hypnotic or Anxiolytic-Related Disorders
- Polysubstance-Related Disorders
- Other (or unknown) Substance-Related Disorders

LISTING OF DC: 0-3R CLASSIFICATION – AXIS I

- Post-Traumatic Stress Disorder
- Deprivation/Maltreatment Disorder
- Disorders of Affect
- Prolonged Bereavement/Grief Reaction
- Anxiety Disorders of Infancy and Early Childhood
  o Separation Anxiety Disorder
  o Specific Phobia
  o Social Anxiety Disorder (Social Phobia)
  o Generalized Anxiety Disorder
  o Anxiety Disorder NOS

- Depression of Infancy and Early Childhood o Type I: Major Depression
  o Type II: Depressive Disorder NOS

- Mixed Disorder of Emotional Expressiveness
- Adjustment Disorder

- Regulation Disorders of Sensory Processing
- Hypersensitive
  o Type A: Fearful/Cautions
  o Type B: Negative/Defiant

- Hyposensitive/Underresponsive
- Sensory Stimulation-Seeking/Impulsive
- Sleep Behavior Disorder
- Sleep-Onset Disorder (Sleep-Onset Protodyssomnia)
- Night-Waking Disorder (Night-Waking Protodyssomnia)
- Feeding Behavior Disorder o Feeding Disorder of State Regulation
  o Feeding Disorder of Caregiver-Infant Reciprocity
  o Infantile Anorexia
  o Sensory Food Aversions
  o Feeding Disorder Associated with Concurrent Medical Condition
  o Feeding Disorder Associated with Insults to the Gastrointestinal Tract

- Disorders of Relating and Communicating
- Multisystem Developmental Disorder (MSDD)

LISTING OF DSM IV CLASSIFICATION – AXIS II

Mental Retardation

- Mild Mental Retardation
- Moderate Mental Retardation
- Severe Mental Retardation
- Profound Mental Retardation
- Mental Retardation Severity Unspecified

Personality Disorders

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder
- Personality Disorder NOS

LISTING OF DC: 0-3R CLASSIFICATION – Axis II

Axis II refers to the quality of the caregiver-infant relationship

- Diagnosing clinicians will factor in the following aspects when assessing the caregiver-infant relationship:
  o Overall functional level of both the child and the parent.
  o Level of distress in both the child and the parent.
  o Adaptive flexibility of both the child and the parent.
  o Level of conflict and resolution between the child and the parent.
  o Effect of the quality of the relationship on the child's developmental progress. *(DC: 0-3R, p. 41)*

- Clinicians use two common measures for assessing Axis II.
  o The Parent-Infant Relationship Global Assessment Scale (PIR-GAS)
    - 91-100 Well Adapted
    - 81-90 Adapted
    - 71-80 Perturbed
    - 61-70 Significantly Perturbed
    - 51-60 Distressed
    - 41-50 Disturbed
    - 31-40 Disordered
    - 21-30 Severely Disordered
    - 11-20 Grossly Impaired
    - 1-10 Documented maltreatment

- o Relationship Problems Checklist (RPCL)
  - Overinvolved
  - Underinvolved
  - Anxious/Tense
  - Angry/Hostile
  - Abusive
  - Verbally Abusive
  - Physically Abusive
  - Sexually Abusive

SOME FREQUENTLY OCCURRING DIAGNOSES

Oppositional Defiant Disorder (ODD)
ODD is a disruptive behavior disorder. It is estimated that 1 to 16% of children and adolescents have ODD. It is more common in males before puberty and females after puberty. A child with ODD will have a pattern of behavior toward authority figures that is negative, defiant, oppositional and disobedient. Medication does not usually help with this disorder. Approaches you may want to use when working with a child who has ODD are:

- Build a trusting relationship
- Focus on here and now behaviors
- Use natural consequences
- Avoid power struggles
- Offer choices
- Keep a positive focus
- Use active listening (see Module 6)

Attention Deficit Disorder (ADD)-Attention Deficit with Hyperactivity (ADHD)
ADD is a disruptive behavior disorder. Recent studies show that on average, 20% of school-age children are diagnosed with ADD/ADHD. In earlier studies the average was 3-4%. It is possible that this drastic increase is due to changing definitions of normal childhood behavior, and possible racial, cultural and gender biases. It is more common in males. Children with ADD can be hyperactive and disorganized, have poor attention and may be impulsive. Medication can be helpful. Some of the things you may want to do if you work with a child who has ADD are:

- Build a trusting relationship
- Keep your work structured, predictable, organized yet flexible
- Give direct and clear instructions

- Help the child refocus his/her attention
- Notice what the child is doing right and give frequent positive feedback
- Engage the child in activities that are interesting to him/her and are active

Post Traumatic Stress Disorder (PTSD)
PTSD is an anxiety disorder. There are 7.7 million People in the United States who have PTSD. Children who are diagnosed with PTSD have had an experience in which they may have felt intense fear, helplessness or horror. There is a wide range of behaviors associated with PTSD; some of these are anxiety, depression, aggression, poor concentration or hyper-vigilance. Medication can be helpful. When working with a child who has PTSD you should create and maintain a safe environment. Some things you can do to create safety are:

- Build a trusting relationship
- Be predictable and consistent
- Allow the child to have some control over choices
- Acknowledge the child's feelings
- Help the child put words to feelings
- Avoid power struggles
- Use active listening (see Module 6)

Depression
Depression is a mood disorder. It is estimated to occur in 5% of children and adolescents in the general population. Males and Females in childhood are equally diagnosed with Depression. In adolescence, females are two times more likely to have depression than males. A child with the diagnosis of Depression often has a persistent sad mood or loss of interest in activities or feelings of worthlessness. S/he may have a change in weight and sleep patterns or difficulty concentrating. Some children will have thoughts of suicide. Medication can be helpful. When working with a child who is suffering from depression, you may want to:

- Build a trusting relationship
- Use active listening (see Module 6)
- Use open-ended questions
- Engage the child in activities
- Be direct about any concern you have about suicide or running away

Bi-polar Disorder
Bi-polar is a mood disorder. It is estimated that 2.6% of the population are diagnosed with Bi-Polar Disorder. Children who have a Bi-polar disorder will have a pattern of abnormally high and low moods. These children can be super happy or

intensely irritable. Medication can be helpful. Approaches you may want to use when working with children who have a Bi-polar disorder are:

- Build a trusting relationship
- Acknowledge feelings
- Be supportive
- Encourage accountability
- Avoid power struggles
- Use active listening (see Module 6)

Autistic Disorder

Autistic Disorder, commonly referred to as Autism, is a pervasive developmental disorder. 3.4 of every 1,000 children are diagnosed with Autism in the United States in the 3-10 age group. Males are 4-5 times more likely to be diagnosed with autism. A child with a diagnosis of Autism may have impaired social interaction, communication and repetitive and stereotyped patterns of behaviors. The symptoms vary widely from child to child. Medication has a limited effect. Some of the strategies you may use when working with a child who has Autism are:

- Build a trusting relationship
- Structure the environment and plan activities
- Build on the child's interests
- Use targeted behavioral interventions
- Use visual cues
- Use sensory supports

Asperger's Syndrome

Asperger's Syndrome is a pervasive developmental disorder. It is estimated to occur in 3% of 1000 children. It is more common in males. A child with this diagnosis may have social skill impairments – failure to develop peer relationships, lack of interest in others and social/emotional reciprocity, and/or restricted patterns of behavior, interests and activities. The symptoms vary widely from child to child. Medication has a limited effect. Some of the strategies you may use when working with a child who Aspergers Syndrome are:

- Build a trusting relationship
- Structure the environment and plan activities
- Build on the child's interests
- Use targeted behavioral interventions
- Use visual cues
- Use sensory supports

Intellectual Disability (Mental Retardation)
Intellectual Disability, formerly referred to as Mental Retardation, is a developmental disorder. Every 3 out of 100 people in the United States have some form of Intellectual disability. An estimated 614,000 children ages 3 to 21 have been diagnosed with Intellectual Disability. It is more common in males. Children with Intellectual Disabilities have lower than average cognitive functioning. There is also impairment in adaptive functioning, such as social skills, communication, self-care and academic skills. The diagnosis is made by administering a standardized test and is still referred to as Mental Retardation in the DSM-IV-TR. The levels of severity are:

- Mild MR – IQ range is 50-55 to approximately 70
- Moderate MR – IQ range is 35-40 to 50-55
- Sever MR – IQ range is 20-25 to 35-40
- Profound MR – IQ range is below 20 or 25
- MR severity unspecified

Medication has a limited role; it might be used to treat anxiety or depression. In your work with a child who has Intellectual Disabilities, you may want to use the following approaches:

- Build a trusting relationship
- Create a structured and predictable environment
- Be consistent and use repetition
- Focus on building

SUBSTANCE ABUSE
According to the Office of Trauma Services in the Department of Health and Human Services, adults who were abused in childhood are more than twice as likely as those not abused to have a higher incidence of substance abuse. It is beyond the scope of this curriculum to cover in depth issues related to alcohol/substance abuse and addiction. However, the SB-BHP needs to be aware of signs of alcohol/substance use or abuse.

An adolescent's dependence on alcohol or drugs usually occurs in several stages. These are:

- In the Experimental Phase, changes that might be observed are that the youth starts missing class, there is a change in his/her peer group and extracurricular activities and there may be a decrease in her/his ability to tolerate frustration.

- In the Crucial Phase, there is usually an increase in the amount of alcohol or drugs that the youth is using, s/he may start sleeping in class, his/her behavior may become inconsistent and her/his contacts with peers are usually connected to alcohol or drug seeking activities.

- In the Chronic Phase, there is an increase in the need for immediate gratification, the youth becomes obsessed with alcohol or drugs, there is no interest in school and deterioration in physical, mental and emotional health.

- In the Rehabilitation Phase, the youth recognizes his/her inability to control his/her use of alcohol or drugs and has an honest desire for help. Her/his thinking becomes more realistic and s/he begins to become aware of others.

TREATMENT MODELS

There are several models for the treatment of alcohol and drug problems. These models may include:

- The Abstinence Model believes that recovery requires completing stopping the use of all alcohol and drugs. In this model, the first step is to help the person move past denial and recognize how the alcohol or drugs are controlling his/her life. Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) support this model.
- The Harm Reduction Model has three core beliefs:
    - Accepts that sobriety and abstinence do not work for everyone
    - Accepts some individuals choose to continue using even when it is not in their best interest
    - Accepts where an individual is on the road to recovery without judgment
- The Responsible Use Model holds that safety and the consequences of alcohol and drug use are important components. It holds that a youth can be taught how to use alcohol. The youth is also taught how to handle him/herself in situations where others are using alcohol or drugs and s/he chooses not to use.

SUICIDE

Sometimes a child or adolescent will seek relief from the symptoms of his/her disability by engaging in self-destructive behaviors such as cutting or eating disorders. Self-inflicted behaviors can be a way to cope with tension, frustration, anger or flashbacks.

Sometimes a child/youth might talk about or attempt suicide. S/he might talk to you about suicide or hurting him/herself. S/he might make indirect statements like "It's not worth living" or "I would be better off dead". Or you might notice cuts on the child's arms or legs. You must immediately report to your supervisor any statements the child makes that seem like s/he may be thinking about suicide. You should report any signs of self-destructive behavior that you hear about or see. It is your responsibility to take the child seriously every time you s/he makes a self-destructive statement or there are signs of self-destructive behavior.

A child may give warning signs that s/he is thinking about suicide. The following are some warning signs:

- Uncharacteristically gives away prized possessions
- Excessive expression of worry, hopelessness, irritability, sorrow or euphoria
- Uncharacteristically isolates him/herself from other people
- Exhibits uncharacteristic high-risk behavior
- Uncharacteristic changes in behavior, like change in grades
- Describes a suicide plan

Speaking to a child or youth directly about your concerns will not put ideas into his/her head. Raising the subject will offer the youth an opportunity to talk about what is on her/his mind. You should discuss with your supervisor how you should respond to a child or youth who talks about suicide and hurting him/herself. School/agency policies concerning the expression of suicidal thoughts by a student will help define the appropriate steps for you to take. You may want to review the following list and establish a set of actions you will take if you are in a situation where you suspect a child or youth might be at risk to harm him/herself.

- Immediately contact your supervisor.
- Inform the child/youth that you need to talk to someone (i.e. parent, supervisor, crisis worker) about the child's risk to harm him/herself.

- Be direct, use phrases like, “Do you feel like killing yourself?” or “Are you feeling suicidal?” These phrases do not prompt thoughts of suicide.
- Ask if s/he is feeling safe or how the environment might be changed to help her/him feel safe.
- Ask her/him if s/he has a plan for killing her/himself.
- If there is a plan, immediately contact Crisis Response:

    - *Region I: 774-HELP or 1-888-568-1112*
    - *Region II: 1-888-568-1112*
    - *Region III: 1-888-568-1112*

Write down the actions you would take if you believed the child you were working with was at risk of harming him/herself.

Competency

B The participant will demonstrate understanding of the role of medications in the treatment of mental health disorders.
(Level 1)

MEDICATION

Medication is used to help the child to manage or remove the symptoms associated with his/her disability in order for him/her to achieve an optimal level of functioning. In most situations, the drug therapy represents one part of a total treatment plan for the child.

A psychiatrist or other medical doctor, such as a pediatrician or family practitioner, determines the use of medication. Medication is often used in the treatment of the following conditions:

- Childhood and adolescent psychosis and pervasive developmental disorder
- Severe behavioral disturbance accompanying MR or clinical emergencies
- ADHD
- Bipolar Disorder (Manic – depressive illness)
- Generalized anxiety
- Major depression
- OCD
- Panic Disorder
- PTSD
- Separation Anxiety
- Sleep disorders
- Tourette's syndrome
- Enuresis

The child's parent(s) may have concerns about having their child taking medications. A parent's concerns and attitudes towards using medication to treat a child's disorder can be complex. The following are some of the concerns a parent(s) may have:

- Fear of side effects
- Fear of labeling
- Fear of addiction
- Fear of child's resistance
- Difficulties in accepting a diagnostic formulation
- Mistrust of medical model

- Denial of mental illness
- Sense of guilt or parental failure

MEDICATION GROUPS AND COMMON SIDE EFFECTS

- Antipsychotics/Neuroleptics:
    - Dry Mouth
    - Urinary retention
    - Constipation
    - Extrapyramidal, which is a disruption in the nerves and muscles controlling movement and coordination symptoms (dystonia/muscle spasm and Parkinsonism)
    - Rash
    - Drowsiness
    - Photosensitivity
    - Long term weight gain
    - Dyskinesia, which is an impaired ability to control movement
    - Anorexia, nausea, abdominal pain
- Stimulants:
    - Insomnia
    - Dysphoria, which is the lack of ability to feel enjoyment at any activity
    - Long term weight loss and tics
- Antidepressants:
    - Cardiovascular symptoms (blood pressure, pulse, arrhythmias)
    - Seizures
    - Irritability
    - Liver and Renal Issues
- Antianxiety/Sedatives/Antihistamines:
    - Over-sedation
    - Rash
    - Disinhibition, which is the inability to suppress (inhibit) impulsive behavior and emotions
- Lithium:
    - Gastrointestinal problems
    - Tremors
    - Memory Lapses
    - Fatigue
    - Goiter
    - Renal problems

- Anticonvulsants (seizure medication):
    - Drowsiness
    - Stomach upset
    - Blood levels
    - Dizziness, light headedness
    - Irritability
    - Elevated liver enzyme

Medications can interact with other medications, prescribed and over-the-counter. There are also some foods which have specific interactions with drugs and alcohol. You should have an understanding of the symptoms the medication is intended to treat, the possible side effects, any specific interactions with food and alcohol and indications of an overdose. This information is easily available at any pharmacy.

Some general signs of overdose include:

- Often accentuated common side effects
- Nausea and vomiting
- Extreme drowsiness, loss of consciousness

Medication policy will vary from school/agency to school/agency. The DHHS has a specific policy that states any one who administers medication must have a CRMA (Certified Residential Medication Aide). *

* From communication with Sandy Dearborn, DHHS-Licensing 2002

Competency

C The participant will demonstrate the ability to formulate a case summary. *(Level 1)*

THE CHILD AS AN INDIVIDUAL

The child you work with, like all of us, is a unique individual. S/he has a 'one of a kind' way of seeing and being in the world. Perhaps the single most important thing you can do in your work as a SB-BHP is to recognize and support the unique set of traits, endearing qualities, interests and the efforts the child makes to cope with the disability. These aspects of the child's functioning are his/her strengths.

You will also want to understand how the child is functioning within her/his current normal developmental phase. There are three (3) areas that you should be familiar with – the physical, cognitive and psychosocial developmental phases. You will also want to understand how the child experiences the symptoms related to his/her diagnosis. A clear understanding of the child's abilities, strengths, and symptoms will help the treatment team to develop and tailor supports and interventions to the child's needs.

Being able to see the uniqueness of the child requires you to keep an open mind. In order to have an open mind, you must keep your assumptions, preconceived ideas, past experiences and biases separate from working with the child. You approach each meeting with a child with a clean slate. Some things that you can do to keep an open mind are:

- Identify the child's style of functioning within the stage of her/his normal development
- Identify the child's strengths
- Notice what you find endearing about the child
- Notice how the symptoms manifest for the child

Before you start to work with a child, you will want to get some background information about them. You will want to have a beginning understanding about the child, which may include the following:

- The record containing pertinent information about the child, which may include developmental history, psychosocial evaluations, reports from

schools/doctors/psychologists/therapists/prior placements/copies of court documents/referral information
- Clarification about who is the guardian
- Clarification about who is involved in the case
- Clarification about who the school/agency had sign a release of information
- Clarification about critical health issues and medications
- Initial identification of the child's strengths
- Initial understanding of the child's limitations, emotional triggers and sources of stress
- Initial understanding of the ITP including current levels of functioning, goals and objectives, current services and responsibilities, and modifications and adaptations
- Clarification regarding your role in delivering services

IDENTIFYING STRENGTHS AND NEEDS

Strengths are the building blocks of success. The following are areas of strengths:

- Things that someone naturally does well
- Interests
- Motivations
- Values
- Skills

You will be evaluating the strengths of the child. Some of the ways to identify strengths are:

- Engage the child in a conversation about their areas of strength
- Notice when the problem does not happen and see what might be preventing the problem
- Notice what the child holds dear, is interested in, does naturally
- Notice what the child does well

For example: a child's strengths might be that s/he likes to draw, is curious and friendly when s/he has clear directions and if given a choice, will do what s/he is asked to do.

You will be evaluating the needs of the child. Current challenges and any unmet need(s) that you notice should be brought to your supervisor's attention.

Think about a child you are working with. What are some of his/her strengths and endearing qualities?

CASE SUMMARY

As a member of the treatment team, one of the things you will be responsible for is sharing your observations of the child with the team. You should be able to describe the child's functioning within her/his developmental stage and how the child experiences the symptoms related to his/her disability. You should be able to prepare a brief written summary of your observations that would include the following:

- The age (year and month) of the child – the stage of physical, psychosocial and cognitive development where the child is on target and where there are delays
- Areas in which the child excels
- The child's interest, passions, strengths
- Things you like about the child
- The child's diagnosis and your observations of the symptoms, when they are present and when they are not present
- Medication(s) the child is taking
- Interventions being used and their effectiveness

DEVELOPMENTAL PERSPECTIVE

Human development is a complex process. There are many factors that influence an individual's development. Human development is the unique interaction between physiology (genetics and maturation), environment, and life experiences. All human beings follow the same developmental path., though the timing, approach and effort required for mastery will vary from child to child. Some children will move through the physical task to mastering walking at an early age, other children will take more time to attempt and completely master walking. Some children will talk within the first eight-months; other children will not talk until age two. This wide variation along the developmental path is normal. Each child is unique with his/her own unique personality and style.

Although we tend to think about development in stages and identify norms for each stage, the developmental norms are relative, not absolute. They are generalizations that help us understand the developmental process. Development is not a rigid sequence of events occurring at specific times in specific ways for everyone. There are seven (6) basic principles of normal development. These are: *

- It occurs from the head downward – the child first gets control over his/her head, then the arms, then the legs
- It occur from the center of the body outward – the child's physical development begins with the spinal cord and then moves to the arms and legs then hands and feet and finally fingers and toes
- It is dependent on maturation and learning – the biological growth is necessary for learning – first the child is able to hold a crayon, then the child learns how to make a mark, then the child learns to make forms, etc.
- It moves from the simple to the complex
- It is a continuous process
- It happens at an individual rate

  * adapted from the Virginia Cooperative Extension

A developmental path or cycle can also be applied to families. Families also tend to follow a predictable developmental path and each family tends to have its own style or tradition connected to each stage. It is important to keep in mind that most children and families, despite their challenges or disabilities, usually fall within a normal range of functioning. A clear understanding of the child's developmental stage will help the SB-BHP to have realistic expectations regarding the child's abilities. The SB-BHP will be able to implement interventions that are matched to the child's developmental level and his/her current skill level.

Development of Stages: (see Table 2-1 and 2-2)

- Infancy (0 – 1)
- Toddlerhood (1 – 3)
- Preschool age (3 – 6)
- School age (6 – 12)
- Adolescence (12 – 18+)

There are a variety of theories that attempt to explain the different aspects of personality development.

Theories of Child Development: (see Table 4-1, 4-2, 4-3, and 4-4)

- Bowlby's Attachment Theory
- Piaget's Theory of Cognitive Development
- Erikson's Stages of Psychosocial Development
- Freud's Stages of Psychological Development
- Sullivan's Interpersonal Development Schema

The Changing Family Life Cycle: (see Table 1-1)

- Leaving home: Single young adults
- The new couple: The joining of families through marriage
- Families with young children
- Families with adolescents
- Launching children and moving on
- Families in later life

bhsi

BEHAVIORAL HEALTH SCIENCES INSTITUTE

4

Module 4 —

Trauma

Activities

Activity 1:
Using a black board, white board or flip chart, draw a line; place a '0' at one end and '10' at the other. Ask the class to identify traumatic events and rate them, 0 to 10; 10 being the most severe. Some questions you might ask:

- Give me some examples of small trauma, such as slamming your finger in a car door or falling out of a tree?
- What are some examples of moderate traumatic events?
- Where would you place growing up in a war zone on this continuum?

Be attentive to creating a broad range of events.

KEEP THIS VISIBLE

What's the Point? To increase the students' understanding of trauma as a universal experience and to expand awareness regarding the range of traumatic events

Activity 2:
Refer to the continuum the class developed in Activity 1. Ask the class to associate responses to the various traumatic events on the continuum. Some questions you might ask:

- Give me some examples of how you might respond to (insert a 0 – 3 item from the continuum)?
- How might someone react to a (insert a 4 – 6 item from the continuum)?

KEEP THIS VISIBLE

What's the Point? To increase the students' awareness of the range of responses to traumatic events

Activity 3:
Refer to the continuum the class developed in Activity 1. Generate a class discussion about safety.

Some questions you might ask:

- What does safety mean to you?
- What do you do when you feel unsafe?
- What would make you feel safe if (insert a 0 – 3 item from the continuum) happened to you?
- What might you do to help a child (insert a 4 – 6 item from the continuum) feel safe?

What's the Point? To increase the students' understanding of strategies for creating safety

Activity 4:
Use a still photograph or video clip that will provoke strong feelings. Ask the class to write a brief description of what they see. Have several volunteers read their notes. Ask the class to identify the objective and subjective elements in the notes.

What's the point? To provide the student with an opportunity to practice distinguishing between objective and subjective observations

Activity 5:

Break the class into small groups (4 - 5 participants each) and give each group one of the following scenarios or create your own. Ask each group to read the scenario they are given and identify statements they might use to recreate a sense of **I HAVE, I AM,** and **I CAN**. Reconvene the class and review and discuss the statements and generate a list of strategies.

Scenario 1
Kelly is a 7 year-old girl. She tells you that children at school called her names. They called her "dumb" and "retardo" because she talks with a lisp.

Scenario 2
Robert is a 4 year-old boy. His mother was due home at 4:00; it is now 6:00 and you have not heard from her.

Scenario 3
Max is a 13 year-old boy. He planned to try out for the track team. The night before try-outs, he sprained his ankle. He will have to wait until next year to try out for track.

Scenario 4
Susan is a 16 year-old girl. She asked a boy to go to the movies with her. He told her he was busy but maybe he could go another time.

What's the Point: To give the students an opportunity to practice using statements that can promote resiliency

bhsi

BEHAVIORAL HEALTH SCIENCES INSTITUTE

4

Module 4 —

Trauma

Content

Module 4 – Trauma

Overview

The School-Based Behavioral Health Professional needs to have an understanding of the effects of trauma. This module provides the School-Based Behavioral Health Professional with an introduction to the identification of trauma and strategies for working with children who have been traumatized.

Competencies

A The participant will demonstrate an understanding of trauma and responses to it. This includes child abuse and neglect as well as other types of trauma that a child or family might have experienced (e.g. medical trauma, witnessing domestic abuse or violence, accidents, war, natural disaster, etc.). (Level 1)

B The participant will demonstrate an understanding of the importance of promoting and maintaining safety for individuals. (Level 1)

C The participant will demonstrate an understanding of resilience and strategies for promoting resiliency. *(Level 1)*

Competency

A The participant will demonstrate an understanding of trauma and responses to it. This includes child abuse and neglect as well as other types of trauma that a child or family might have experienced (e.g. medical trauma, witnessing domestic abuse or violence, accidents, war, natural disaster, etc.) (Level 1)

A WORD ABOUT TRAUMA

Trauma is a common human experience. Everyone at some point in his/her life has something happen which takes her/him by surprise. S/he feels overwhelmed by a lack of control and safety. The experience could be a physical one, for example, a car accident or a winter ice storm that cuts off electrical power for weeks. The experience could be a psychological one, for example, the death of a loved one or witnessing the collapse of the Twin Towers on 9/11/01. The experience could be physical and psychological, for example, childhood abuse or parenting a child who is physically aggressive.

Everyone will have an emotional or psychological reaction to the traumatic experience and the reaction is unique for each person. Also, the reaction might change how the person behaves. For example, one reaction to being in a car accident might be that the person becomes insistent that everyone has their seatbelt fastened before the car is started, while another reaction might be that the person gives up driving.

As you learn about trauma, you will bring your own unique experiences to the information you hear. It is important to remember that during and after a traumatic event, each of us used our unique set of resources and found a way to handle and make sense of the experience; and today we are doing our best to understand and live with the experience.

THE DEFINITION OF TRAUMA

Trauma is defined in the Merriam-Webster Collegiate Dictionary as: 1 a: an injury (as a wound) to living tissue caused by an extrinsic agent <surgical *trauma*> b: a disordered psychic or behavioral state resulting from mental or emotional stress or physical injury 2: an agent, force, or mechanism that causes trauma.

WHAT THE EXPERTS SAY

Bruce Perry, M.D., PhD. defines trauma as "a psychologically distressing event that is outside the range of usual human experience. Trauma often involves a sense of intense fear, terror, and helplessness." Dr. Perry has free on-line courses at www.childtrauma.org.

Beverly James, a specialist in evaluating and treating traumatized children, defines trauma as overwhelming, uncontrollable experiences that impact individuals by creating a feeling of helplessness, vulnerability, loss of safety, and loss of control.

TRAUMATIZING EVENTS

Traumatic events can be divided into two categories: (1) Non-interpersonal or environmental events and (2) Interpersonal events.

Non-interpersonal events are things that happen in the environment that are unexpected and overwhelming. In these situations, the event that is traumatic is not an action of another person. Types of non-interpersonal events are:

- Natural disasters – earthquakes, tsunami, ice storms, fire, etc.
- Accidents – car, falling off a jungle gym, losing a limb, etc.
- Medical – sudden illness, painful and prolonged treatment, etc.
- Death of a loved one
- Witnessing a non-interpersonal event – seeing a car accident.

Interpersonal events are person to person. In these situations, a person is being maltreated by another. The person who is being hurt is often dependent and less powerful. For example, a child in day care is dependent on the day care provider and has less power or ability to influence and control the relationship. All experiences of maltreatment will result in some degree of traumatization. Types of interpersonal maltreatment are:

- Neglect – emotional, physical, etc.
- Physical – hitting, kicking, burning
- Sexual – overt i.e. touching, or covert i.e. as exposure to x rated movies
- Emotional – shaming, blaming, bullying
- Witnessing person to person violence

MALTREATMENT, ABUSE, AND TRAUMA

Child maltreatment is defined as: 1. A child who is found to have experienced a substantiated event of physical and/or emotional abuse and/or neglect. 2. A child who is at risk to experiencing physical and/or emotional abuse and/or neglect that could be substantiated.

Abuse is an event. It is a description of the facts of the event.

Trauma is the unique way in which a person experiences the event and how s/he responds to it. It is important to keep in mind that each child's response is unique. Two children may experience the same event but each child will have his/her own unique response to it. All abuse events are traumatic and all responses to abusive events are highly individualized.

According to DHHS Child and Family Services and Child Protection Act (Title 22 – Chapter 1071, Subchapter I), abuse and neglect "means a threat to a child's health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection from these, by a person responsible for the child."

Children are dependent on adults for their basic survival needs and for the nurturance they need to develop and grow. Adults have more power in the relationship because children are dependent and in many situations, an adult can make a child do what he/she wants. Children have less resources and ability to defend themselves. This means that children are more vulnerable to experiencing the effects of traumatic events.

According to 2008 statistics from the US Department of Health & Human Services: (For addition information and current statistics: US Department of Health &Human Services Administration for Children & Families: www.acf.hhs.gov/index)

- 48.3 % of child victims were boys and
- 51.3 % of child victims were girls
- 15.0 % per 1,000 with a disability
- 32.6 % per 1,000 in the same age group were under age 4
- 18.9 % per 1,000 in the same age group were between 4 – 7 years

THE IMPACT OF TRAUMA

During the last 25 years, experts have studied and researched the effects of trauma. Currently there are two schools of thought about how traumatic events affect people. One school of thought is the medical model; the other is the trauma model.

The medical model sees responses to trauma as symptoms of abnormality or disease that are the result of the events. Because of the traumatic event, the person develops pathological behaviors.

The trauma model sees the responses as adaptations, a person's best efforts to cope with the traumatic event. The person's behaviors are specific strategies for coping with the event.

Studies have shown that trauma affects the brain, body and mind. Each child will have his/her unique way to cope with his/her experience. One way to think about how trauma impacts a child is that her/his brain becomes focused on surviving. S/he seems to always to be alert to possible threats and is prepared to fight, flight or freeze as a way to protect her/himself. S/he is not making conscious decisions about how to behave; her/his brain is being protective. This means, if the child's brain thinks that what is happening is harmful, it will cause changes to happen in the brain and these changes will cause the child to behave in a certain way.

When the brain goes into a fight mode, the child might become physically aggressive. If the brain is in a flight mode, the child might run away. If the brain is in a freeze mode, the child might become spacey.

Other ways the brain might affect a child is to change his/her ability to distinguish between what is safe and dangerous, or to adjust to strong feelings such as joy or anger, and s/he may have difficulty putting feelings into words.

Because the brain is focused on surviving, it makes connections to things that happened during the event. These connections are called triggers. Triggers will cause the brain to go into a fight, flight or freeze mode. Since each child's response is unique, the child will also have unique triggers. A trigger will be something that was connected to the events. It could be a sight, sound, smell, thought, or a time of day or activity.
A traumatic event can change a child's beliefs, thoughts, feelings and behavior. The child might have a sense of being betrayed and may feel a loss of belonging and safety. S/he may start to believe that the world is not a safe place and people cannot be trusted. S/he may have reoccurring or intrusive thoughts about her/his experience. The child might feel anxious, suspicious or sad, s/he might start taking unusual risks, or change his/her sleeping and eating habits. Often times a child's ability to focus on school work is affected. S/he may have poor concentration or poor attention span.

It is important to remember that each child's response is unique. A child's age, temperament and the condition surrounding the event are factors that will effect how the child responds to the experience. Factors that impact a child's response are: how long the event or series of events took place, the child's concern for

his/her safety, who was involved, physical injury, and the level of disruption of her/his connection to caregivers.

A WORD ABOUT ATTACHMENT

Attachment is a close bond between a child and a caregiver who provides comfort and security. Attachment happens during infancy and early childhood. The kind of attachment the child forms will influence his/her ability to form emotional connections.

Bonding experience, like safe touch and holding, eye contact, smiling and fulfilling basic needs for things like food, clothing, and shelter, are the activities that help form secure attachments. Things that influence attachment are:

- Temperament – infants who are difficult to comfort may have more difficulty forming a secure attachment
- Caregivers – inconsistent, critical, rejecting or interfering behaviors may limit emotional closeness
- Environment – unsafe and chaotic situations can cause vulnerability to developing attachment problems
- Fit – lack of compatibility between the caregiver and child's temperament

Problems with forming attachments can impact a child's emotional, physical and cognitive development as well as the ability to form emotional connections. Like trauma responses, the child's ability to form relationships can be seen as adaptive responses to his/her bonding experiences.

There are 4 types of attachments:

- Securely attached
- Insecure – avoidant
- Insecure – resistant
- Insecure – disorganized and disoriented

REACTIVE ATTACHMENT DISORDER OF INFANCY OR EARLY CHILDHOOD

This diagnosis is made when a child age 5 or younger shows symptoms of very disturbed relationships to others and the behavior is developmentally inappropriate. There must also be evidence of grossly pathological care. This disorder has two types, Inhibited, when the child fails to initiate or respond to social interaction, and Disinhibited, when the child responds to most people as attachment figures.

POST TRAUMATIC STRESS DISORDER (PTSD)

This diagnosis is made when there as been an extreme stressor in the life of the child that results in either reliving the experience or avoiding the experience, and there can be difficulty sleeping, increased irritability, exaggerated startle response, poor concentration, and hypervigilance.

Sometimes the diagnosis of PTSD can be missed. This may happen because there is not a full understanding of the traumatic event or because the child's adaptive behaviors may be extremely aggressive or defiant behavior or numbing or withdrawal. Diagnoses that may be made by mistake are:

- Oppositional Defiant Disorder (ODD)
- Attention Deficit and Hyperactivity Disorder (ADHD)
- Depression
- Anxiety Disorder (i.e. panic disorder, social anxiety disorder)

DIFFERENTIAL DIAGNOSIS

It may take careful observation by the licensed clinician for a period of time before an accurate diagnosis can be made. Your objective observations about the child's mood and behavior will provide the clinician with valuable information.

The Differential Diagnosis is a systematic method of diagnosing a disorder that lacks unique symptoms or signs. It involves comparing and contrasting many observations about the child, which may include physical signs, symptoms or tests.

OTHER DIAGNOSES FOR CHILDREN EXPOSED TO EXTREME STRESS

PTSD is not the only diagnosis that can be made when a child has a change in mood or behaviors following a traumatic event. Other diagnoses that can be made are:

- Adjustment Disorder
- Mood Disorder
- Acute Stress Disorder
- Obsessive-Compulsive Disorder
- Schizophrenia or other Psychotic disorders

TREATMENT

The only people who provide treatment for PTSD and the other diagnoses listed above are licensed professionals, including psychiatrists, psychologists, LCSWs, LCPCs or psychiatric nurse practitioners. As a SB-BHP, it is unlikely that you will be involved in a child's therapy sessions.

You are responsible for following the ITP and to document the child's progress toward meeting his/her goals and also any significant information that relates to the child's ITP.

FAMILIES AND COMMUNITIES

Traumatic events can affect families and communities. Families may pass traumatic responses from one generation to the next. This may happen because the parent's own adaptive behavior unintentionally creates a lack of safety. For example, when under stress, the parent's adaptive response is to space out. This response could create unsafe situations for the child, which in turn could lead to traumatic events for the child. Another idea about how trauma might be passed on is that the parent has difficulty teaching coping skills, such as self-soothing or handling strong feelings, to the child.

Traumatic events, such as the bombing in Oklahoma City, the Tsunami that affected India, Indonesia and Africa, or high crime rate in a neighborhood, can affect an entire community. Research is now being done to gain a better understanding of the intergenerational affects of trauma and also the impact of trauma on communities.

Your role as a SB-BHP is to foster a professional relationship with the child that creates safety, is accepting and respectful, and is open to seeking to understand the other's experiences. The focus is on supporting the child to meet their goals.

Reflect on a time when something startled or scared you. What were your reactions? What helped you feel safe? _____

_____

_____

_____

SIGNS OF VICARIOUS TRAUMA

Unlike trauma, which is an event or events, Vicarious Trauma is a process that happens when one listens to and sees the pain and disruption of trauma. Every time you hear someone's traumatic story you experience strong feelings like sadness, outrage, repulsion or despair. When these feelings build up over time, they cause VT. The person telling his/her story does not cause the VT; it is the natural consequence of compassionately witnessing another's experience. There are many signs of VT. These include, but are not limited to:

- "Shutting down" – having no emotional response
- Feeling hopelessness or despair
- Change in your feelings for the child, losing respect or positive regard
- Having work thoughts interfere with your non-work time
- Nightmares that seem related to work
- Starting to see the world as an unsafe and unfriendly place
- Feeling fearful or that things are more dangerous
- Overly tired, aches and pains, frequent colds
- Lack of appropriate professional boundaries
- Avoiding reflecting on your experience

ADDRESSING AND TRANSFORMING VICARIOUS TRAUMA

The effects of VT can be successfully managed. The first step to managing VT is to have a daily plan that includes the following:

- Self-care – knowing what your emotional, physical and spiritual needs are and making sure that they are met.
- Self nurturing – spending some time every day doing something that replenishes you, enjoying a hot bath or shower, listening to your favorite music, meditating, reading, writing, drawing, etc.
- Escape – giving yourself time away from the day-to-day activities, creating a fantasy vacation, watching TV or a movie, sitting and staring out the window, etc.

The effects of VT can be transformed. This means bring new meaning to your experience. Ways to do this are:

- Create meaning – find new ways to understand your experience and find new understanding in your experience.
- Bring meaning to your mundane daily activities – find something unfamiliar in the familiar, notice the sensory aspects of a routine activity, or notice your emotional connection to a daily routine.
- Recognize and change negative beliefs – make an effort to notice when you shift from optimism to cynicism and from hope to hopelessness. Make a conscious decision to change your negative beliefs.
- Build a strong and varied support network – have reliable co-workers, friends and family who can listen to you and support you.

Develop your own self-care plan. _____

Competency

B The participant will demonstrate an understanding of the importance of promoting and maintaining safety for individuals. (Level 1)

SAFETY

An essential task in your work as a SB-BHP will be to establish and maintain safety with the child and family. Creating safety includes making sure the child is physically safe at all times and paying attention to the child's emotional safety as well. Working collaboratively and offering encouragement will help to foster safety.

Remember that trauma is a universal experience. The child you work with may not have a diagnosis of PTSD or Reactive Attachment Disorder. Regardless of the child's diagnosis, you should show the child the same concern for his/her safety and offer comfort and support for her/his emotional experiences.

It may not always be obvious that the child is feeling unsafe. The indicators are unique for the child and s/he may not be able to articulate feeling unsafe. There may be signs indicating the child is experiencing a loss of safety. These could include, but are not limited to:

- the child engaging in rocking, thumb or finger sucking, biting oneself, hesitant in play
- the child may make statements of worry or have some obsessive behavior
- the child may make negative statements about oneself, be overly demanding or passive, be cruel to others
- the parent(s) or caregiver may unintentionally or intentionally create unsafety by blaming or putting the child down, be cold or being aloof or withholding attention or affection, indifference to the child's problem

There are a number of things you can do to create safety. Paying attention to the following strategies will help to create safety and it will also help you create an environment that supports the child's ability to make changes.

- Being predictable – helping the child understand what will happen next helps to create a sense of safety. Things that help create predictability are;
    - Helping the child understand what is expected of him/her
    - Having routines
    - Saying what you mean and meaning what you say

- Clear rules for specific reasons and reasonable consequences

- Consistency – doing things the same way and responding to things in the same way. For example, each time you work with the child you start your shift with reviewing what you will be working on. Being consistent does not mean being rigid and there may be times when you need to be flexible. If you start your shift with reviewing the goals and sometimes the child has something important to tell you, you would listen to the child first and then begin your usual routine. Sometimes consistency is a delicate balance between following the same pattern and making slight changes.

- Encouragement – encouraging the child and acknowledging her/his accomplishments, small and big, help to support positive self-esteem and promote safety. Encouragement is also an effective motivator. You will want to be very specific when acknowledging what the child is doing well. For example, "You did a good job letting me know you are angry; you yelled and stomped your foot. You aren't hitting and throwing things. You are really getting a handle on your anger."

- Attending to emotions – emotional safety is as important as physical safety. You will need to support the entire range of feelings the child may experience. When you support a child's emotional experience, you are offering comfort, acknowledging what is being felt and being open and curious about what the child is feeling. For example, a child says to you, "I hate you! You are stupid! Get away from me!" You might say, "You don't like me being here and I guess you feel I'm pretty stupid and can't help you. What is the dumbest thing I've done so far?" This approach helps the child feel understood and also offers him/her an opportunity to express his/her thoughts and feelings in a healthy and safe way.

- Listening – a child may start talking about a traumatic event or difficult situation. Sometimes it is hard to listen to stories about traumatic events. It may take great effort for you to listen with an open mind. It will be important for you to give the child all of your attention and accept what the child is saying without overreacting to what is said or avoiding it by changing the subject. Letting the child say what s/he needs to say without asking probing questions or offering solutions will support the feeling of safety.

- Physical safety – if a child does not feel physically safe, you will not be able to help him/her feel emotionally safe. Sometimes the issues of physical safety will be obvious, such as safety crossing the street. There may be situations where the physical safety issues are more complex. There might be things in the environment that are triggers for the child, such as sounds or smells. You may need to pay careful attention to the details in the environment in order to identify and eliminate the triggers. It will be important for you to discuss with your supervisor your observations and ideas about what might be trigging the child. Together you can develop a plan on how to help the child and manage the triggers.

- There may be times when it would be helpful to talk with the child about how s/he can help her/himself to feel safe. Before engaging in a conversation with a child on how s/he could create safety, you should discuss this with your supervisor. Some of the questions you and your supervisor might consider asking are:

    - Do you remember a time when you felt safe?
    - Do you feel safe right now? (At this moment)
    - Do you remember a time when you felt safe with someone?
    - What makes you feel safe? (Certain people, objects, etc.)
    - What do you keep with you that makes you feel safe or loved? (Teddy bear, pillow, blanket, locket, picture)
    - What could you do to make yourself feel safe?
    - What do you do when you feel scared?
    - Are you good at something?
    - Is there a part of you that is okay right now?
    - How can I help you feel safe?

You will need to objectively document your observations, the strategies you used to help the child feel safe and the child's response to those strategies. Clear documentation about your work with the child will help everyone involved to understand and develop the best intervention to help the child.

A WORD ABOUT THERAPEUTIC HOLDS

You must be certified in a recognized practice for therapeutic holds. Some of these methods are MANDT, NAPPI or CPI. Both DOE and your school/agency have regulations on the use of therapeutic holds. It is your responsibility to have a full understanding of these policies. You must make every effort to create a safe environment for the child. Most of the time you will be able to help the child feel

safe and remain in control of her/himself. You should also do everything you can to avoid using a therapeutic hold.

There may be situations in which the child is at risk, like starting to run into the street. You will want to stop the child and may need to hold him/her. You should be very clear about your reason for holding the child. You should clearly explain your reason for holding the child and then promptly contact your supervisor and tell him/her about the incident. You should also write up an incident report.

IMPORTANCE OF SELF CARE

You will find that your direct care of a child with emotional, behavioral or developmental disabilities is both rewarding and challenging. You will experience great satisfaction when you see a child progress toward meeting her/his goal. You will also experience extreme frustration, disappointment or concern when struggling to meet his/her goal or when you see the child regress or when you listen to the parent(s) talk about her/his frustration. These feelings are a normal part of working in a profession that supports people's growth and requires you to be empathic.

In work situations where most of the children you work with are experiencing severe responses to trauma, there is a strong likelihood that you may experience Vicarious Trauma (VT). Unlike Burn-Out, which is the experience of physical and emotional exhaustion that is usually associated with the lack of adequate support and difficulty renewing one's energy, Vicarious Trauma is a response to hearing about and seeing the effects that trauma has on children. VT is also known as compassion fatigue and secondary trauma.

When you use yourself, your feelings, talents, attention, etc., to help a child meet her/his goals, you will be depleting your energy. When you listen to or see the effects of child abuse or trauma, you will have strong feelings that could alter how you see yourself and the world. It is your responsibility to make sure that you have enough energy, compassion and mindfulness to give the child the best care possible.

PROTECTIVE STRATEGIES

It is unlikely that you will only work with children who have experienced trauma. Nonetheless, it is important to put in place some strategies that will help you maintain a healthy level of energy and attention. These are:

- Understanding the signs of VT
- Identifying the things in your work that could cause VT
- Making a plan for how you would cope with VT
- Using the following tools everyday:
    - Awareness – pay attention to all parts of your experience. Check in with yourself and notice what is going on with:
        - Thoughts
        - Feelings
        - Physical reactions
        - Things you are avoiding
        - Things you are wishing
        - How you are making decisions

      When you notice something is really different, get curious about it and find out what caused the change.
    - Balance – keep equal amounts of work, fun, rest, self-reflection and learning in your life.
    - Connection – build respectful, supportive and caring relationships with your co-workers and supervisor. Nurture meaningful relationships with family, friends and find a source of spiritual renewal.

EXERCISE

You have been working with Mary for 8 months. She has a diagnosis of ADHD. There has been improvement in her ability to focus and she is less impulsive. You work with Mary as her 1:1 during gym class. You notice that over the past week Mary has been refusing to get changed for gym class despite earning detention as a consequence. When you suggest that she change for gym class, she yells in your face, saying she's never going to gym class again. She continues to yell and begins punching the wall. This is unusual behavior for Mary. Today in class you notice that when a peer touched her arm lightly, Mary jerked back as if in pain.

How would you intervene in this situation? Describe how you would create physical and emotional safety for Mary. What would you say to her? What issues will you want to discuss with your supervisor? How would you document your interactions with Mary?

Competency

C The participant will demonstrate an understanding of resilience and strategies for promoting resiliency.
(Level 1)

RESILIENCY

All of us have the ability to be resilient. Resilience is the ability to face, overcome, and be strengthened by adversities. Some of the skills we use are:

- Insight – asking yourself hard questions and giving yourself honest answers
- Independence – developing healthy boundaries
- Relationships – connecting with other people who are nurturing
- Initiative – managing problems
- Creativity – finding meaning in troubling experiences
- Humor – being able to laugh
- Morality – trying to do the right thing

A caring adult who offers a child hope by advocating for and believing in the child can help support his/her resiliency.

Children can learn to be resilient. You can help a child develop resilience. Giving the child honest, positive feedback about his/her positive traits will create a foundation that the child can work from and build on. Helping a child identify his/her positive traits will help build resiliency.

I HAVE – identifies feelings of safety and security
- Trusting relationships
- Positive role models
- Encouragement to be independent

I AM – identifies personal strength
- Loveable
- Able to love others

I CAN – identifies social and interpersonal skills
- Talk to people
- Solve problems
- Manage feelings
- Understand others

A child does not have to have every one of these traits. A combination of several of them can help build resiliency.

Dr. Bruce Perry has identified six (6) core strengths that can support a child to have a solid foundation for emotional health. These are:

- Attachment – this is being able to have caring, respectful relationships to others, family and friends
- Self-Regulation – this is the ability to notice feelings and needs and get them met in a supportive manner
- Affiliation – this means being able to belong to a group
- Awareness – this means being able to notice needs, interests, feelings and values of others
- Tolerance – this is the ability to understand and accept difference
- Respect – this is the ability to appreciate self-worth and the worth of others

You are a witness to the child's experience. Sometimes the simple act of seeing who a child is and what he/she is experiencing can help a child be resilient.

A FINAL WORD

Given what you know now – that trauma is a universal experience, which affects how our brains function, alters our beliefs and that we are all responding to our experiences with our best abilities – your orientation towards yourself, the people you work with, the people you love and the strangers you meet, should be one of compassion and recognition of your shared experience.

bhsi

BEHAVIORAL HEALTH SCIENCES INSTITUTE

5

Module 5 —

Individual Treatment Plan

Activities

Activity 1:

Use one or more of these exercises.
1. Show a short video clip (3 or 4 minutes of something that has human interaction).
2. Show the students three different photographs (preferably photographs which are ambiguous and others that are clear).
3. Use an audiotape clip with the entire class. Then have the students complete the same worksheet.

Give students several minutes to write down their observations on the sample worksheet below. Generate a class discussion, point out the factors the students used in making their observations, i.e. objective observations-specific details, subjective observations-thoughts, feelings, ideas about what was seen/heard.

WORKSHEET

Objective Observations	Subjective Observations
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

What's the Point? To allow students to demonstrate understanding of objective and subjective observations

Activity 2:
As a homework assignment, write this web site on the board:

www.authentichappiness.org.

Ask the students to go online and take "The VIA Signature Strengths Survey and 17 more happiness questionnaires" and report back to the class on their 5 Signature Strengths.

What's the Point? To expand the students' understanding of strengths and give them the opportunity to identify what their inherent strengths are.

bhsi

BEHAVIORAL HEALTH SCIENCES INSTITUTE

5

Module 5 —

Individual Treatment Plan

Content

Module 5 – Individual Treatment Plan

Overview

This module addresses the basic competencies necessary for the School-Based Behavioral Health Professional to function as a member of the team that develops and implements the Individual Treatment Plan which includes the Individual Education Program (IEP). The treatment planning model, reading and interpreting treatment plans, recording, reporting, and observation and identification of strengths and needs are all topics included in this module.

Competencies

A The participant will demonstrate the ability to read and interpret the Individual Treatment Plan including the Individual Education Program and Crisis Plan. (Level 2)

B The participant will demonstrate the ability to objectively observe and accurately record the child's progress.
(Level 2)

Competency

A The participant will demonstrate the ability to read and interpret the Individual Treatment Plan including the Individual Education Program and Crisis Plan. (Level 2)

SCHOOL-BASED BEHAVIORAL HEALTH PROFESSIONAL

As a School-Based Behavioral Health Professional your work with children is defined by an Individual Treatment Plan (ITP). This plan includes the student's Individual Education Program (IEP) and a MaineCare documentation addendum which adds both a crisis plan as well as an area for signatures and credentials for all participants.

INDIVIDUAL TREATMENT PLAN

The MaineCare Section 65 Day Treatment Clinician, and the MaineCare Section 28 Supervisor work with the family to develop the Individual Treatment Plan (ITP) in order to provide reimbursable SB-BHP services. The ITP is based on assessments and other progress measures used to determine the child's current level of functioning. The ITP is based on assessments and is completed within 30 working days. It is signed by the child (if appropriate), family, and the clinician or supervisor. It serves three purposes:

- Treatment – it describes the treatment the child will receive
- Fiscal – it is required for reimbursement
- Legal – it is proof of the treatment the child received

You should think of the ITP as being your blueprint or road map for working with the child. It will provide you with directions on how to help the child meet his/her goals. The problem, goal, objective, method, and measurement statements are directly connected to the SB-BHP's work. The ITP must contain:

- Problem Statement
- Goal Statement
- Objective Statement
- Method/Action/Strategy Statement
- Measurement Statement
- Provider(s) Responsible
- Start Date
- Completion Date

- Frequency of Service

The Objective Statement is what the child will do to meet the goal. It should be a clear, concise statement. There can be one or more objectives for a goal.

The Method/Action/Strategy Statement is what a member of the treatment team will do to help the child complete the objective. It should be clear and concise. There can be one or more method/action/strategy statements for an objective.

The Measurement Statement is how the objective will be measured. It should be written in measurable terms.

The Provider(s) Responsible is the person(s) who will be working with the child to help him/her achieve the objective. It should identify a person. One or more people can be responsible for working on an objective.

The Start Date is the date the child will start working toward the goal.

The Completion Date is the date the child is expected to achieve the goal.

The Frequency of Service indicates how often the objective will be worked on. It should identify a time frame.

If you are familiar with what an Individual Education Program is, you might realize that many of the components found within an Individual Treatment Plan are familiar to you. Despite similarities between the IEP and the ITP however, both are unique documents, each serving specific and differing purposes.

INDIVIDUAL EDUCATION PROGRAM (IEP)

+

MAINECARE DOCUMENTATION ADDENDUM

=

INDIVIDUAL TREATMENT PLAN (ITP)

INDIVIDUAL EDUCATION PROGRAM

Children enrolled in public schools and who are receiving Special Education services must have an Individual Education Program (IEP). An IEP is an individualized document designed with a specific set of goals and objectives unique to each student. These goals, and the manner in which these goals are to be met, must take into consideration the needs and personal characteristics of each child. By doing so, the IEP helps to connect the child with appropriate accommodations in an effort to improve their educational experience.

*By law, the IEP must include certain information about the child and the educational program designed to meet his or her unique needs. In a nutshell, this information is:

Current performance. The IEP must state how the child is currently doing in school (known as present levels of educational performance). This information usually comes from the evaluation results such as classroom tests and assignments, individual tests given to decide eligibility for services or during reevaluation, and observations made by parents, teachers, related service providers, and other school staff. The statement about "current performance" includes how the child's disability affects his or her involvement and progress in the general curriculum.

Annual goals. These are goals that the child can reasonably accomplish in a year. The goals are broken down into short-term objectives or benchmarks. Goals may be academic, address social or behavioral needs, relate to physical needs, or address other educational needs. The goals must be measurable, meaning that it must be possible to measure whether the student has achieved the goals.

Special education and related services. The IEP must list the special education and related services to be provided to the child or on behalf of the child. This includes supplementary aids and services that the child needs. It also includes modifications to the program or supports for school personnel, such as training or professional development that will be provided to assist the child.

Participation with nondisabled children. The IEP must explain the extent (if any) to which the child will not participate with nondisabled children in the regular class and other school activities.

Participation in state and district-wide tests. Most states and districts give achievement tests to children in certain grades or age groups. The IEP must state what modifications in the administration of these tests the child will need. If a test is not appropriate for the child, the IEP must state why the test is not appropriate and how the child will be tested instead.

Dates and places. The IEP must state when services will begin, how often they will be provided, where they will be provided, and how long they will last.

Transition service needs. Beginning when the child is age 14 (or younger, if appropriate), the IEP must address (within the applicable parts of the IEP) the courses he or she needs to take to reach his or her post-school goals. A statement of transition services needs must also be included in each of the child's subsequent IEPs.

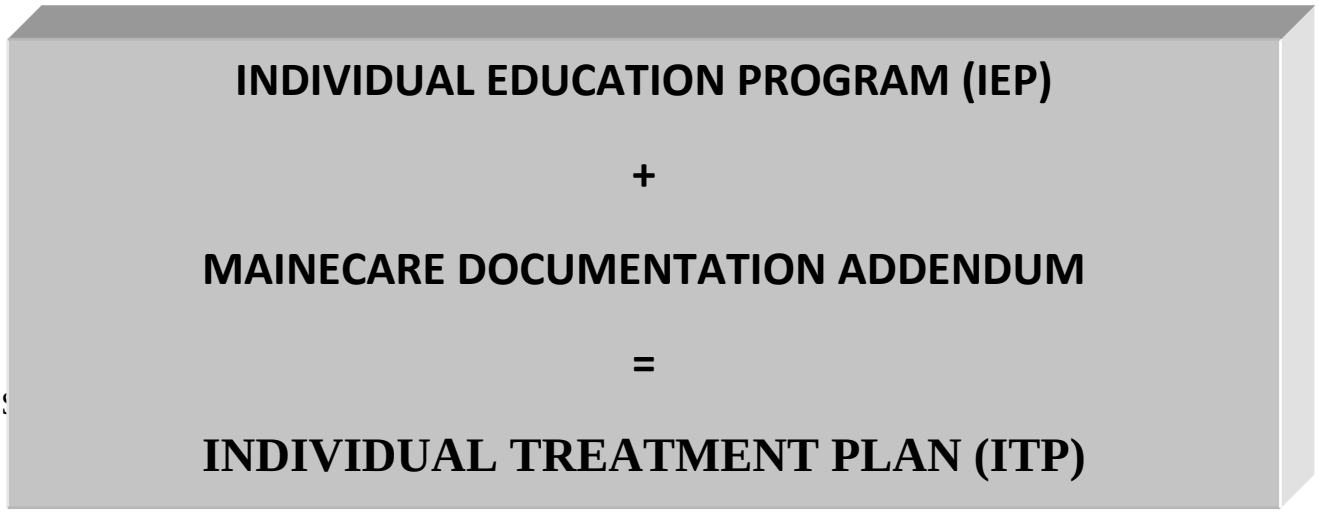
Needed transition services. Beginning when the child is age 16 (or younger, if appropriate), the IEP must state what transition services are needed to help the child prepare for leaving school.

Age of majority. Beginning at least one year before the child reaches the age of majority, the IEP must include a statement that the student has been told of any rights that will transfer to him or her at the age of majority. (This statement would be needed only in states that transfer rights at the age of majority.)

Measuring progress. The IEP must state how the child's progress will be measured and how parents will be informed of that progress.

(*Taken from the U.S. Department of Education A Guide to the Individualized Education Program; http://www.maine.gov/education/speced/iep_guide.htm)

To meet the guidelines set forth by MaineCare for the provision of services under Section 65 Day Treatment and/or Section 28 RCS School-Based, Children must have an Individual Treatment Plan. More specifically, a child must have an Individual Education Program including a MaineCare documentation addendum. The addendum includes a crisis plan and signatures, parental and client signatures with credentials for all participants.



CRISIS PLAN

There are basically two types of potential crisis. One is with the child – a behavioral outburst, illness or accident. The other is an unforeseen event for the SB-BHP – violent disturbance in the child's neighborhood, a car accident or illness. In a crisis situation, the anxiety level of the people involved goes up. When anxiety goes up, thinking abilities go down. A pre-established crisis plan outlines the expectations for those involved in the resolution of the crisis. A crisis that is managed well can bring about positive change.

The team (including the child and family) develops the crisis plan. It should define "worst case scenarios". The plan should clearly and concisely specify what each person should do in a crisis situation. The following factors should be considered when developing a crisis plan:

- What has happened in past crises; specifically, interventions that worked and did not work
- Consider the possible environments in which a crisis may occur; identify factors in the environments that should be changed during a crisis
- Consider the worst things that could happen based on past behaviors
- Create need-based interventions; formulate as many interventions as possible
- Pre-plan the interventions with the people who may be involved in the crisis resolution
- Explore with the child and family what they think could go wrong with the plan
- Identify the criteria for determining when the crisis is over

Things to consider in a crisis plan for the SB-BHP are:

- Identify all of the potential crises the SB-BHP might have
- Establish protocol for:
    - Who will be notified and when
    - Giving information about the child
    - Providing back-up for the SB-BHP

It is important to evaluate the management of the crisis when it is over and review the following:

- How the communication protocols worked
- How crisis responsibilities were handled

- The interventions that were used and how they worked
- The child and family's perception of the crisis management response

A good crisis plan should have the following elements:

- A description of the triggers or warning signs that a crisis might happen
- What the child will mostly likely do when the crisis is escalating
- What people, places or things are known to increase escalation of the crisis
- hat you should do (these are things that worked in the past to de-escalate the child)
- What the child will do when s/he is in a full blown crisis
- The things you should do to create safety
- The people you can and/or should contact

You should follow your school/agency's policy for what to do after a crisis is resolved. This policy should include writing an incident report and debriefing with someone as soon as possible.

You may be part of another service plan for the child. For example, you may be asked to help the child practice speech and language exercises. Everything you do with a child must be part of the child's ITP. A good rule of thumb is:

IF WHAT YOU WANT TO DO OR ARE ASKED TO DO
<u>IS NOT</u> ON THE ITP – DO NOT DO IT!

Identify the steps you would take if the child you were working with became engaged in a physical confrontation with another student.

Competency

B The participant will demonstrate the ability to objectively observe and accurately record the child's progress.
(Level 2)

OBSERVING

Observing and reporting are two important tasks that you will be performing as a SB-BHP. Observing is the gathering of information by noting facts or events. Reporting is giving an accurate account of a fact or event(s). You must strive to become an Impeccable Observer. An Impeccable Observer is someone who can keep notice of two things at the same time. S/he can notice what is happening in the environment and s/he can notice her/his thoughts and feelings. An Impeccable Observer can accurately see, hear and respond appropriately to what is happening without his/her thoughts or feelings getting in the way. Becoming an Impeccable Observer requires diligent practice. Your supervisor is someone who can help you practice this.

Every time you work with a child, you will want to look for changes in the following:

- level of safety and surroundings
- family interactions
- health and medical issues
- insight and judgment
- connections to the community
- activities of daily living
- social interactions
- mood and behavior
- impulsive behavior

Some of the questions you can ask yourself when you notice changes are:

- What exactly has changed?
- How is it different?
- When did it change?
- Did something happen to cause the change?
- Does the team need to meet to talk about this change?

Being a good observer requires a great deal of awareness and practice. You will want to understand how you observe things. Some people notice all of the details

and sometimes miss the big picture; other people notice the big picture and miss many of the small details; some people observe a combination of the big picture and the details. Remember that your beliefs and life experience will influence what you observe.
We all have personal biases, beliefs, and attitudes that can influence observations. You will be working in home environments that will be very different from your own. The family may have very different ideas about neatness, cleanliness, and good nutrition. You may encounter different religious beliefs, races, cultural norms, and work ethics. It will be important for you to identify your personal biases, beliefs, and attitudes. A personal bias is a preference. A personal belief is a certainty. An attitude is a feeling. Your ability to understand your own personal biases and beliefs will help you to objectively report what you see and experience in your work.

You will be evaluating risk and safety factors that involve the child's behavior and also the physical environment. These might involve the child's intent to harm him/herself and/or his/her ability to follow directions. All risk and safety concerns must be discussed with your supervisor and a plan for responding to them should be developed.

There are two types of observation skills that will be important for you to master. The first type is *objective* observation. These observations are the concrete facts, such as the behaviors that you see, the statements the child or family makes, and the reports from school or other providers involved with the child and family. The second type is *subjective* observation. These observations are your interpretations of an event or conclusions you reach that are based on your feelings, judgments or your response to another person's feelings. You need to know when you are making an objective observation and when you are making a subjective observation.

Most observations are a combination of objective and subjective. Each type provides valuable information to the treatment team. Some of the things that you will be observing on a regular basis are the level of safety, mood, behaviors, strengths and limitations, and your own thoughts, feelings, and reactions.

When reporting your observations, you should begin with a description of the objective observations and end with your subjective observations. Because a subjective observation is your thoughts or feelings about something, you should start a subjective statement with a phrase like "it seemed…" or "the child appeared to…"

Your school/agency will have a method and format for reporting your contact with the child and family. Information that should be included in a progress note is:

- client's name, full date, duration of the contact
- a summary of the goal that you worked on
- the progress made towards the goal
- new observations or information
- your signature with credentials

Label the following sentences as Objective or Subjective or a combination of the two.

- When we got to the fair, Ralph ran across the road. I ran after him and when I caught him, I held his left arm so he would not run off again.

  _____

- Freda was very mad at me because her teacher kept her in at recess.

  _____

- Judy covered her ears when I played the radio. She doesn't like music, but she needs to get used to it if she want to fit in with the other kids at school.

  _____

RECORDING

Records are important for a number of reasons because they:

- Meet Medicaid and other medical and mental health reimbursement and licensing requirements
- Are proof that a service was delivered
- Show the progress that is being made toward meeting the goals
- Help determine the methods/strategies/actions to incorporate into the treatment plan

All documentation should be legible, clear, concise, accurate, and complete. Most notes will include *Qualitative* and *Quantitative* data. Qualitative data tends to be descriptive and refers to the quality of an interaction or event. It may describe a child's temper tantrum as less severe than ones in the past. Quantitative data refers to something concrete and measurable. It may state that the child had four temper tantrums in one day.

When writing a summary of an objective that was worked on, you should make a general statement about what occurred while you were working on that objective. Support the statement with specific observations. Include any new behavior or need that you have observed.

DOCUMENTATION

The Progress Note is a record of the child's progress. It is also a legal and fiscal document. Each note must include the following:

- Child's name
- Date and service hours
- Objective that was worked on
- Progress towards goals – improved, same, regressed
- Narrative of what occurred during the service hours
- SB-BHP signature and credentials

In the narrative section of the progress note you will be recording what you did and what you observed during your time with the child. These should be general statements without too much detail. Statements should be supported with specific observations. Avoid judgmental language. Statements that are interpretative should begin with words like, "It seemed" or "It appeared". There also may be areas to indicate whether or not the child saw a Speech-language Pathologist or Occupational Therapist, participated in a community outing

You need to keep in mind that the child and family have a right to access their record. It is a good practice to review your notes to see if anything that you have written might be seen as judgmental or inaccurate.

The Incident Report is another piece of documentation that you might need to complete. An incident report should be written whenever a crisis or problematic event occurs, such as observing an interaction that causes you to suspect that abuse or neglect has or might occur. Each school/agency will have a specific policy and format for incident reporting that you should be familiar with.

bhsi

BEHAVIORAL HEALTH SCIENCES INSTITUTE

6

Module 6 —

Communication Skills

Activities

Activity 1:

Ask the students to remember a time when they felt someone was really there for them. What did that person do to convey his/her concern for their situation? [Looking for qualities i.e. empathy, compassion, non-judgmental, listening, recognizing or validating, encouraging, being supportive and hopeful]

What's the Point? To increase the student's awareness of the qualities that a BHP should bring to her/his work

Activity 2A: Attending

Break the class into pairs. Ask each pair to identify a speaker and a listener.
Ask the speaker to talk for 2 – 3 minutes about something that is important to him/her (i.e. politics, family, a stressful situation – something the student feels comfortable with sharing).
After 2 – 3 minutes, ask the speaker in each pair the following question, "Do you feel like you are being listened to? What did your partner do that made you feel that you were or were not being listened to?" Write the speakers' observations on a white board.

Discuss the qualities associated with attending.

What's the Point? To give the students an opportunity to experience and identify some of the components of attending

Activity 2B: Acknowledging

Ask the students to change roles. Ask the new speakers to talk for 2 – 3 minutes about a strong like or dislike – something the student feels comfortable with sharing. Ask the listeners to convey to the speaker that s/he understands what the speaker is saying and if necessary, ask for more information.

After 2 – 3 minutes ask the speakers in each pair the following: "Do you feel like you were understood? What did your partner do that made you feel that you were or were not being listened to?" Write the speakers' observations on a white board.

Discuss the qualities associated with Acknowledging and Reflecting.

What's the Point? To increase the students understanding of the various qualities associated with the 3 components of Active Listening - Attending, Acknowledging and Reflecting

Activity 2C: Active Listening

Give this list of sentences to a student in the first row. Ask him/her to say the statement, conveying the emotion with tone of voice and body language to the student next to him /her. The listener will use the following skills: active listening, attending, acknowledging the content of the message and reflecting back to the speaker the emotion attached to the statement.

1. You are not the boss of me. I don't have to do what you say.
   Angry
2. They laughed at me. My friends sat there and laughed at me. I felt like a fool.
   Embarrassed
3. It's going to be great! I can't wait to get started!
   Excited
4. Oh no! … don't make me go. I can't talk to him.
   Scared
5. Everyone thinks she is so cool.
   Jealous or Worried
6. I'll never do anything right. Why should I try?
   Frustrated or Angry
7. I was mean to her. I shouldn't have done that.
   Guilty or Sad
8. My father promised me he would call last weekend and he didn't.
   Worried or Angry
9. Go away; leave me alone. I don't care what happens to me anyway.
   Sad
10. I guess I should finish it, but maybe it would be better if I didn't … or maybe … what do you think I should do?
    Uncertain
11. I don't want to leave yet. Those kids are always mean to me.
    Scared
12. For a while, I was doing well but now I'm worse than before. I try hard but it doesn't seem to help. What's the use?
    Disappointed, Frustrated, or Sad
13. I never want to see him again. I wish that creep would drop dead.
    Scared or Angry
14. Everyone's talking about the party. Who cares about a stupid old party anyway? It will be stupid.
    Disappointed or Lonely
15. I don't need a hat and gloves. It's my body; I can do what I want.
    Angry or Hostile
16. I'm fed up with my uncle. He's always telling me what to do.
    Frustrated or Angry
17. Everyone's gone to the movies. What's there to do?
    Bored
18. I got a B on my spelling. That's the best I've ever done!
    Glad or Proud
19. She is my best friend. We do everything together.
    Love
20. I think if I practice every day that I'll be able to make the team.
    Hope

What's the Point? To give each student the opportunity to demonstrate her/his skills in active listening

Activity 3: "I" Message

Relate one of the following problems (or compose his/her own) to each student. Each student will formulate an "I" statement and say it aloud.

1. The child is using an empty plastic milk bottle as a percussion instrument on the desk.
2. The child is refusing to wear her coat outside on a windy, crisp autumn day.
3. The 12 year-old girl, dressed provocatively, is leaving to go gym class.
4. The child has just injured his toe by kicking the steps in frustration.
5. The 11 year-old is saying he is going to take home the laptop computer and you can't stop him..
6. The child has just pulled his classmate's hair.
7. The teacher has walked out of the bathroom with toilet paper around her shoe.
8. The child is pacing back and forth in the classroom for an hour before his Big Brother is due to pick him up at school.
9. The child has just yelled at you and told you he wishes you had never come to his class.
10. The teacher has "forgotten" an appointment with you for the second time this week.
11. The parent has taken the child off his prescribed medication because a television reporter suggested it might not be safe.
12. The speech therapist arrived an hour late.
13. The mother has just yelled at you and told you to mind you own #*#! business.
14. The uncle has just slapped the child across the back of the head because he refused to be quiet.
15. The child insists that he can drink the caffeinated soft drink 30 minutes before bedtime.
16. The child is refusing to take a shower for the sixth day in a row.
17. The parent agrees to the ITP in the team meeting but, when you go to the house, the parent tells you that the plan won't work.
18. The child insists you told him you would take him for a ride in your car.
19. Your supervisor tells you not to worry about a crisis plan for the new family you are working with because they never have a crisis.
20. The mother tells you she is planning to leave her husband and asks you to hold $500.00 for her.

What's the Point? To give each student an opportunity to practice using an "I" statement

bhsi

BEHAVIORAL HEALTH SCIENCES INSTITUTE

6

Module 6 —

Communication Skills

Content

Module 6 – Communication Skills

Overview

The School-Based Behavioral Health Professional needs to be skilled in listening to others and in clearly and accurately communicating their ideas verbally as well as in writing. This module addresses the particular issues of using these skills within a school environment.

Competencies

A The participant will demonstrate knowledge of basic human relation skills.
(Level 1)

B The participant will demonstrate the ability to listen empathetically and sensitively.
(Level 2)

C The participant will demonstrate the ability to communicate clearly using oral and written modes of communication.
(Level 2)

D The participant will demonstrate the ability to communicate within a group setting.
(Level 2)

E The participant will demonstrate knowledge of nontraditional modes of communication.
(Level 1)

This module on communication assumes that both parties have adequate hearing, speaking and processing skills. The SB-BHP may work with a child who faces some type of communication difficulty. Although the same principles apply for effective communication, the method of communication may vary. The SB-BHP will need to seek guidance from his/her supervisor about how to process and manage challenges in communication.

Competency

A The participant will demonstrate knowledge of basic human relation skills. (Level 1)

BUILDING A WORKING ALLIANCE

The most important resource you will bring to your job as a SB-BHP is yourself. You will be using yourself in ways that will encourage change, growth and healing. You will assist the child in learning and practicing new skills, keep the child safe, and promote positive self-esteem. Your relationship with the child will be the foundation upon which change will occur.

You will need to build a positive relationship with the child; this is your working alliance. Some of the ways to build and maintain a working alliance are:

- Creating a safe and supportive environment for the child
- Encouraging mutual liking, respect and trust
- Having the same set of goals
- Agreeing about how the goals will be met
- Communicating effectively

You are friendly, but you are not a friend. A friendship is based on mutual interests, common experiences and give-and-take. In a working alliance, all interactions are focused on assisting the child with meeting their goals. You will be a role model, teach new skills, and support the child with practicing the new skills.

Unconditional positive regard is necessary for a strong working alliance. It means you see the each person as having worth and value because s/he is a human being. A person's "inappropriate" behavior does not decrease his/her worth. There are many ways that you can demonstrate unconditional positive regard, such as being:

- Professional
- Understanding
- Consistent
- Respectful
- Yourself

Professionalism is having expertise in relationship skills that will enable the child to feel safe, empowered and supported. It means you are non-judgmental; you look at the facts or listen to what is being said without labeling something good or bad. You acknowledge differences in opinions and are confident that an understanding

can be reached. You identify and learn from success and mistakes. You stay curious about what the child is doing and his/her reasons for what they are doing.

Demonstrating an interest in understanding the child involves being able to see a situation through his/her eyes. You will want to first seek to understand instead of being understood. You will want to allow the child to express his/her point of view first. You will gain an understanding of him/her by listening and asking questions. You will want to do this without making the child feel like you are prying.

Consistency and predictability means always following through with what you say you will do. This will help you to create safety and build trust. You can do this by keeping the appointments you set, following through with what you say you will do, and stating your expectations clearly. When there are differences of opinion, you point out the differences and show confidence that they can be worked out.

Some of the ways you can demonstrate respect are to show up on time, call in advance if you need to change an appointment, negotiate instead of dictate, acknowledge that being a child is hard work, follow the same rules the child is expected to follow, , and expect respect in return.

You must be yourself in order to effectively help the child. You should acknowledge your feelings and take responsibility for them. You should admit to your shortcomings. You should be truthful and acknowledge when you don't know something. You are a role model for the child; he/she will be watching to see how you handle your feelings and shortcomings.

Meeting a child for the first time can be stressful. It may be helpful for you to read the clinical record and talk with your supervisor. As you learn about the child, you will want to keep an open mind. Look for places of strength as well as areas where there are unmet needs.

Sometimes it is helpful to prepare what you will say when you meet the child for the first time. The initial introduction usually sets the tone for the working alliance.

How would you explain your role to the child? How will you learn about the child's interests?

How would you introduce yourself to a parent? What would you say about your role and responsibilities?

You will experience challenges and successes in your work with the child and family. It will be important for you to help the child understand the difference between being a friend and a caring adult. Showing the child that you understand their feelings and maintaining your professional boundaries can help you avoid the disappointments that can happen when you cannot meet the expectation of a friendship with the child. Your relationship with the child will go through many stages. Discussing the relationship on a regular basis in supervision can help you maintain a healthy working alliance with the child.

What could you say to a child who tells you that you are their best friend?

Competency

B The participant will demonstrate the ability to listen empathetically and sensitively.
(Level 2)

THE COMMUNICATION PROCESS

Communication is the act of sending and receiving information or messages. Message can be sent verbally and/or non-verbally. Sending and receiving information or messages is a process. Having an understanding of the process of communication and how messages are sent and received will enable the SB-BHP to become an effective communicator.

The flow of the process starts with a sender, who composes a message with verbal or written words and/or a facial expression or body language. The message travels through an environment, which may or may not have an impact on the receiver's ability to understand the message. The receiver forms an understanding of the message and composes a response, which is based on the receiver's understanding of what was said. And the process continues on.

If you have ever played the 'Telephone Game', where a statement is whispered into one person's ear and that person whispers it into the next person's ear and so on, you may recall how different the message was that the first person heard and the last person said. The 'Telephone Game' is a fairly accurate example of how most communications work. You may think you are sending a clear message and

the receiver may think s/he understood you correctly, only to find out as the conversation moves along that there was a misunderstanding.

CONVERSATIONAL STYLES

There are two parts to a message: the information and the metamessage. The data (the words or gestures that have specific meanings) is the information. How the data is delivered (the intent or purpose) is the metamessage. For example, if someone said "Well, that's the best news I've heard all day!" and it is spoken with a harsh tone and the person is frowning, the metamessage may be to show displeasure with the information or the person delivering it.

Each of us has a conversational style; it is all of the things we do when we are sending a message. Your style is shaped by your culture and flexibility with various conversational styles. Conversational styles tend to happen automatically and we often form impressions about the speaker based on his/her style. Often, when someone is talking and listening to you, they are forming an opinion about you that is based on your style.

A conversational style may be to make a comment as the speaker is speaking and the intent is to show interest. The speaker may experience this as an interruption and form the opinion that you are rude. Or, a style may be to let the speaker complete her/his thought before responding. The speaker may perceive that lack of comment as disinterest and form the opinion that you don't care.

ACTIVE LISTENING

"Good talking starts with good listening." Faber & Mazlish.

Active listening means giving your full attention to hearing and understanding what someone is saying to you. When you are actively listening, you are paying attention to what the child is doing and saying and what s/he needs or wants right now. You are not thinking about what you will say next. You are trying to fully understand the child's thoughts and feelings.

Sometimes the child may not know or be able to fully express his/her thoughts and feelings. Active listening will encourage the child to become aware of what s/he is feeling and to talk about it. When you actively listen, you will be demonstrating unconditional positive regard and helping to build a trusting relationship.

There are 3 parts to Active Listening:

- **ATTENDING** – means concentrating with your ears, eyes, body and feelings. You are noticing your own body language, your own feelings and your eye contact, making sure that you are sending a message that says you want to hear what the child is saying. Being silent usually encourages a child to talk. However, you may need to encourage the child with small phrases such as "tell me all about it", "uh huh", "go on", or "I see". You can also encourage the child with your facial expressions.

- **ACKNOWLEDGING** – means you pay attention to the child's body language, tone of voice, eye contact, and use of language. Your aim is to be open to the child's point of view and to understand what s/he is saying. Offering reassurance or sympathy can help a child talk more about what s/he is thinking or feeling. You may want to restate what is said or ask clarifying questions to ensure that you are getting the message the child is sending. There are three types of questions you can use:
    - Open Ended – look for more information; these are "how" and "what" questions.
    - Closed Ended – are useful for gathering factual information; these are "who", "when", and "where" questions.
    - Why questions – encourage the child to understand his/her motive or reason. Use these questions carefully. A child can become defensive when asked a "why" question.

  You can also acknowledge by:
    - Summarizing – restate the important points in what the child said. This is a useful way of checking that you received the message the child wanted to send.

- **REFLECTING** – means letting the child know you understood what s/he said and how s/he might be feeling. It is important for the child to know that you are paying attention to his/her feelings. There are several ways to do this:
    - Reflecting – involves saying back to the child the thoughts and feelings that were connected to what s/he said. For example:
      Child – "He let the cat go!"
      SB-BHP – "You didn't like it when he let the cat go. It made you mad."
    - Interpreting – explaining the possible meaning of what the child said. For example: SB-BHP – "You got mad when he let the cat go because you worry about the cat when he's outside."

- Synthesizing – bringing together the facts, thoughts, feelings, and actions in an effort to help the child learn something. For example: SB-BHP – "You care a lot about the cat. And when you worry, you get mad. I think sometimes when you are mad and are yelling and throwing things, that you are really feeling worried about something."

You may not always understand what the child is feeling. Sometimes when you are reflecting back to the child what you heard and how you think the child feels, the child will tell you that you are wrong. When this happens keep an open mind and use encouragement and open-ended questions to help the child express his/her feelings. You might say something like, "I know this is really important to you, and I really want to understand it. "Please tell me more about it." or "I didn't get it, what do I need to understand?"

Active listening is an art and a skill. You will be promoting healthy communication with the child and family. Part of role modeling active listening skills will involve being patient with yourself and with others and practicing all the different aspects of active listening.

Active Listening Dos and Don'ts:

DO
- Put yourself in the speaker's shoes.
- Concentrate on what is being said.
- Recognize your own biases.
- Listen for what is not said.
- Listen for the attached emotion.
- Notice the non-verbal message.

DON'T
- Try to listen and talk at the same time.
- Jump to conclusions.
- Offer solutions.
- Dismiss the child's feelings.

Effective Active Listening will help the child to:
- Learn about his/her feelings
- Problem solve
- Develop positive self-esteem
- Identify and name feelings
- Develop coping skills
- Feel secure and respected

- Build a trusting relationship

Active Listening is not intended to:

- Be the only response to a child. Some situations may require making a direct statement.
- Be an opportunity for a child to manipulate the situation.
- Be a complete parroting of content.
- Be a miraculous, all-purpose approach.
- Be a complex, time-consuming activity.

You will make mistakes. It is a normal part of communication. Your responsibility is to recognize your mistake, acknowledge what you did, and repair hurt feelings. The best strategy for repairing a miscommunication is a simple apology. For example: "I am sorry what I said hurt your feelings. I didn't mean to. I will try not to let it happen again."

Describe some of the ways in which you are a good listener.

Identify 3 things that you can do to improve your listening skills.

Competency

C The participant will demonstrate the ability to communicate clearly using oral and written modes of communication.
(Level 2)

COMMUNICATING

Clear communication is an essential function of the SB-BHP. You will be relating your observations to the treatment team and giving instructions to the child on the behavior skills s/he needs to develop and master. You will be writing progress notes and other documentation that your school/agency might require.

We send messages to other people by our facial expressions, tone of voice, and words. A study by Mehrabian in 1969 showed that 55% of the message we send is communicated through our facial expression, 38% through our tone of voice, and only 7% with words. Careful attention to how you communicate with your body language and words will impact your effectiveness with teaching new skills, problem solving, and reporting.

You have your own unique way of learning and processing information. Perhaps you learn best by listening, by seeing, or by doing - or some combination of the three. The child will have his/her own unique way of processing information. It will be important for you to pay attention to his/her style and communicate your message in the way that the child will understand it best.

COMMUNICATION STYLES

Communication styles are often associated with personality types. There are many different ways of learning about your personality type. One model that is widely used is the Meyers Briggs (www.myersbriggs.org). This model identifies four (4) basic traits: Introvert or Extrovert, Sensing or Intuition, Thinker or Feeler, and Judging or Perceiving, which form 16 different personality types. These 16 types can be grouped into four (4) communication styles: doers, thinkers, influencers and connectors. Marcia Reynolds discusses communications styles in the following article. The following is a reprint, with permission, of her article.

4 Dominant Communication Styles

Although there are many different personalities, communication styles can be broken into four major profiles. If you take into consideration the needs of each style when communicating with others, you have the greatest chance of establishing rapport and trust**.** Ignore the styles and you risk rubbing people the wrong way, possibly shutting down the possibility of gaining the results you want. In addition, when you acknowledge your own dominant style, you can build on your strengths and set goals to adapt or ask for help in areas you avoid. The styles are based the most important needs when communicating, whether it be on achievement or on relationship, on idea creation or on action.

The two styles most focused on task:

Doers like to be in control. They like quick action and they like to see results. They like to get to the point with little formalities. They don't care for details and love finding shortcuts. Otherwise, they get bored easily. They like autonomy, freedom and taking risks. They are self-starters, innovators and love to expend physical energy. They like public recognition, especially for putting what they most value into action and for creating results that make a difference in the world (or at least in world they see and act in every day).

Thinkers love to gather information. They enjoy reading and presenting their findings in detail. However, they need to mentally rehearse before they present, and take time to evaluate and wind down after the show. They take their time making decisions, but stand by what they decide once they do. They don't care to talk about personal issues, but enjoy discussing hobbies and issues. They desire clear expectations, specific goals, deadlines and structure. They live by a sense of order, methodologies and personal responsibility. Thinkers love to win, and will compete with themselves if no one is available. They will jump into the game with no coaxing if they perceive they have a fighting chance. They are proud of their good work. They like acknowledgment but won't ask for it.

The two styles most focused on relationship:

Influencers like to verbally process their thoughts so they welcome situations where they can "think out loud" with others. They like to interrupt others, especially when they are excited about the topic. They view this as conversation, not a disruption. They enjoy people, desire approval and tend to be friendly, creative and persuasive. However, they may need some help staying on track and following through on tasks. They desire social interaction, acknowledgment and chances to be creative and have fun. They often see the bright side and can be very amusing, dramatic and passionate about work. They help others get through difficult times and can build rapport and support. They genuinely like people. However, they might find themselves caught up in a lot of drama since they are quick to want to help fix things and people. Teasing is one of their favorite pastimes.

Connectors count on others to set the tone and determine direction. They are consistent and reliable once given their responsibilities. They like to work with others instead of alone but take their time trusting and allowing new people to join their established groups. They do not readily give opinions, but this does not mean they don't have any. Because they are diligent and dependable, they often know the most about how work is getting done. They like to be asked what they know and they appreciate personal recognition (done privately, not in front of others). They desire consistency, social bonds and acknowledgment for effort as well as results. Although they may appear stubborn, they can be very flexible and adaptable if they understand why the changes are being made and how they will benefit themselves and others. They seek to reduce stress and promote harmony. www.outsmartyourbrain.com.

COMMUNICATION TIPS

Doers tend to be high achievers and leaders and drive necessary results. They also tend to be impatient and insensitive to others. When communicating with a doer style:
~ Be clear, specific, brief and to the point.
~ Stick to business.
~ Be prepared to support your ideas and work.

Factors that will create tension or dissatisfaction:
~ Talking about things that are not relevant to the task or issue.
~ Being unprepared or incomplete. Avoiding or beating around the bush.
~ Appearing unsure or disorganized, but not asking for help.

Thinkers tend to excel when they like their work and can think through all angles and contingencies. They can appear to be combative, critical and sarcastic. When communicating with a thinker style:
~ Prepare your "case" in advance. Be prepared for a debate.
~ Stick to business.
~ Be accurate and realistic.

Factors that will create tension or dissatisfaction:
~ Being giddy, casual, informal, emotional or loud.
~ Pushing too hard for results or being unrealistic with deadlines.
~ Being disorganized or messy.

Influencers can lighten up even the darkest of moments. They can be inspirational, understanding and encouraging. They can also be wishy-washy in their decision-making and seem impractical. They are often late on assignments they do not like. When communicating with an influencer style:
~ Provide a warm and friendly environment. Do little things to show your care.
~ Don't deal with a lot of details (put them in writing).
~ Ask "feeling" questions to draw their opinions or comments.

Factors that will create tension or dissatisfaction:
~ Being curt or cold. Cutting them off if they have something to say.
~ Controlling the conversation. Not allowing them to talk and express.
~ Focusing on facts and figures.

Connectors are reliable team players who look after everyone in their "tribe." They are consistent and caring. They can also be stubborn and non-supportive of pushy people and what they judge to be impulsive ideas. When communicating with a connector style:
~ Begin with a personal comment--break the ice.
~ Present your case smoothly, non-threateningly.
~ Ask "how?" questions to draw their opinions.

Factors that will create tension or dissatisfaction:
~ Rushing headlong into business. Creating tension.
~ Being domineering or demanding.
~ Forcing them to respond quickly to your ideas. Demanding change

There is a difference in how boys and girls and men and women talk. In general, boys tend to have very few words for feelings and girls tend to have lots of words for talking about feelings. Boys are more likely to talk when they are doing something, like shooting hoops. Girls will often talk at length about their feelings and problems.

The rate of processing information varies from person to person. Some individuals understand quickly while others take longer to fully grasp the information. Generally, people take in information in one of the following ways: auditory, visual, or kinesthetic or some combination of the three.

You will want to be sensitive how your style of talking and the child's are the same and different. You may need to adapt the way you talk so that it will fit better with the child's style of talking.

COMMUNICATION TOOLS

You will need to master a number of different communication tools for different situations. Some of the things you will need to know how to do are giving directions, establishing a rule, setting a limit or giving feedback. A rule of thumb for any type of communication is to be **RICH**:

R – be **R**espectful

I – be **I**nformative and **H**elpful

C – be **C**onnected to the child

H – be **H**opeful

There will be many circumstances in which you will be giving the child directions or instructions, for example, when you are asking the child to do something or are teaching a skill. The following are guidelines for giving directions:

- Be sure that what you ask is reasonable and appropriate.
- Talk in a calm, firm voice.
- Ask him/her to repeat what you have said.
- Give one step at a time.
- Keep the directions simple and be specific.
- Avoid giving direction for something in the future … keep it in the 'here and now'.

- Use physical closeness that is comfortable.
- Make eye contact.
- Be prepared to change your method, such as drawing something or showing what you want the child to do.

Write the steps you would take, and what you would say, when giving a child direction on how to ask a librarian for help with finding a book on rabbits.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

There are three (3) basic tones that can be used to communicate: Passive, Aggressive, and Assertive.

- A Passive tone avoids conflict.
- An Aggressive tone tries to make others accept the speaker's point of view.
- An Assertive tone tries to promote productive communication.

PASSIVE, AGGRESSIVE, AND ASSERTIVE COMMUNICATION

PASSIVE

Verbal Behaviors:

You avoid saying what you want, think or feel. If you do, you speak in such a way that you put yourself down. Apologetic words with hidden meanings, a smoke screen of vague words, or silence are used frequently. Examples are "You know," "Well," "I mean," "I guess," and "I'm sorry." You allow others to choose for you.

Nonverbal Behaviors:

You use actions instead of words. You hope someone will guess what you want. You look as though you don't mean what you say. Your voice is weak, hesitant, and soft. You whisper in a monotone. Your eyes are averted or downcast. You nod your head to almost anything another person says. You sit or stand far away from

the other person. You don't know what to do with your hands, and they are trembling or clammy. You look uncomfortable, shuffle, and are tense or inhibited.

Goals:
To please, to be liked

Feelings:
You feel anxious, ignored, hurt, manipulated, and disappointed with yourself. You are often angry and resentful later.

Payoffs:
You avoid unpleasant situations, conflicts, short-term tensions, and confrontations. You don't have to take responsibility for your choices.

Other person's Feelings:
They feel guilty, superior, frustrated or even angry.

Their Feeling Toward You:
They feel irritated. They pity and depreciate you. They feel frustrated or disgusted with you. They lose respect for you because you are a pushover.

Probable Outcomes of This Type of Behavior:
You don't get what you want. If you do get your own way, it is by indirect means. You feel emotionally dishonest. Others achieve their goals at your expense. Your rights are violated. Your anger builds up, and you either push it down or redirect it towards other people who are less powerful. You may find yourself procrastinating, suffering in silence, doing things halfheartedly, being sloppy or being forgetful. Others manipulate you. Loneliness and isolation may become common in your life.

AGGRESSIVE

Verbal Behaviors:

You say what you want, think and feel, but at the expense of others. You use "loaded works" and "you" statements and one-upmanship. You choose for other.

Nonverbal Behaviors:

You make an exaggerated show of strength. You are flippant. You have an air of superiority. Your voice is tense, loud, cold, or demanding. You are deadly quiet. Your eyes are narrow, cold, and staring. You almost see through the other person. You take a macho fight stance. Your hands are on your hips, and you are inches from the other person. Your hands are in fists or your fingers are pointed at the other person. You are tense and appear angry.

Goals:

To dominate and humiliate

Feelings:

You feel self-righteous, controlling, and superior. Sometimes you feel embarrassed or selfish later.

Payoffs:

You get some anger off your chest. You get a feeling of control. You feel superior.

Other person's Feelings:

They feel humiliated, depreciated, or hurt.

Their Feeling Toward You:

They feel hurt, defensive, humiliated, or angry. They resent, distrust, and fear you. They may want revenge.

Probable Outcomes of This Type of Behavior:

You often get what you want but at the expense of others. You hurt others by making choices for them and infantilizing them. Others feel they have a right to get even. You may have increasing difficulty with relaxing and unwinding later.

ASSERTIVE

Verbal Behaviors:

You say what you honestly want, think, and feel indirect and helpful ways. You make your own choices. You communicate with tact and humor. You use "I" statements. Your words are clear and objective. They are few and well chosen.

Nonverbal Behaviors:

You listen closely. Your manner is calm and assured. You communicate caring and strength. Your voice is firm, warm, and expressive. You look directly at the other person, but you don't stare. You face the person. Your hands are relaxed. You hold your head erect, and you lean toward the other person. You have a relaxed expression.

Goals:

To communicate, to be respected

Feelings:

You feel confident and successful. You feel good about yourself at that time and later. You feel in control, you have self-respect, and you are goal-oriented.

Payoffs:

You feel good. You feel respected by others. Your self-confidence improves. You make your own choices. Your relationships with others are improved. You have very little physical distress now or later. You are in touch with your feelings.

Other Person's Feelings:

They feel respected or valued. They feel free to express themselves.

Their Feeling Toward You:

They usually respect, trust, and value you. They know where you stand.

Probable Outcomes of This Type of Behavior:

You often get what you want if it is reasonable. You often achieve your goals. You gain self-respect. You feel good. You convert win-lose to win-win. The outcome is determined by above-board negotiations. Your rights and others' rights are respected.

Source: Charlesworth, E. & Nathan, R. (1984). Stress Management. New York: Atheneum.

You will want to develop an assertive style of communication. Strategies for assertive communication are:

- Being clear about what needs to be communicated
- Choosing the right time and place
- Being specific and to the point
- Being calm and respectful
- Having good eye contact and a direct posture
- Using "I" messages

There will be times when the child is engaging in problem behaviors and you may experience feelings of frustration, worry or confusion. In these situations you will want to use an "I" statement to convey your thoughts and feelings as you try to direct the child to behave in a positive manner. The "I" messages help you state what you are experiencing without shaming, blaming or attacking the person. You will be taking responsibility for how you feel, which can in turn invite the other person to have a conversation with you about the issue. For example: This statement – "For Pete's sake! If I've told you once, I've told you a million times not to leave your plate out for the ants to find! What's the matter with you?" could cause the person being spoken to, to become defensive. Whereas, this statement – "I am frustrated when you leave your dirty dishes beside the couch because it attracts ants." could help the person being spoken to understand more about how the speaker feels.

A pattern for the "I" statement starts is:
"I feel _____, when you _____
because _____.

Some of the feeling words you might use are:

Angry	Confident	Engaged	Happy	Lonely	Surprised
Anxious	Confused	Exhausted	Hopeful	Sad	
Ashamed	Depressed	Frightened	Hysterical	Scared	
Cautious	Ecstatic	Frustrated	Jealous	Shocked	

For example, "I feel <u>scared</u> when <u>you run ahead of me</u> because <u>you might get hurt</u>."

An "I" statement is an effective way of giving the child feedback about his/her behavior. The statement begins with you stating how you feel about what the child

is doing or saying. You are telling the child about your experience. The second part of the "I" gives a description of what was said or done and the third parts explains why you feel the way you do.

Another example is "I feel frustrated when you refuse to work on your practice playing fair goal because I'm not helping you to learn to get along with your peers."

"I" statements can also be used to give the child positive feedback. For example, "I feel hopeful when you to say focused on your chore because I can see that you are making progress."

There are many circumstances in which the use of an "I" statement can be an effective way for you to express your thoughts and feelings. When you use an "I" statement, be sure to pay attention to your tone of voice and your facial expressions. The non-verbal message you send should be the same as the verbal one. You will be showing the child how you feel by the tone of voice you use and your facial expression. Also, chose words that will not shame or blame the child, but are respectful.

Many different things can disrupt communication. Many times what happens is not intentional. You may be eager to help, anxious about what is being said or distracted. Being a good listener takes lots of practice and a willingness to correct habits that can create barriers. Some of the things that disrupt effective communication are:

- Interrupting
- Providing solutions
- Labeling
- Passing judgment
- Criticizing
- Shaming
- Blaming
- Showing boredom
- Multi-tasking

If you make a mistake, be willing to say so. You will role model for the child that mistakes are a normal part of learning new skills. Making mistakes can cause a disruption in the working alliance. Noticing a mistake and apologizing by simply

saying, “I am sorry that what I said hurt your feelings. I will try not to let it happen again.” can be an effective way to repair a disruption in the working alliance. When you make an apology, be sure that you understand what happened and that you are stating it correctly. You might say, “I think I may have miscommunicated something to you, what did you think I was saying?” or you could say “This conversation seems to be getting off track, what can we do to get it back on track?” Understanding what happened can help the SB-BHP learn more about him/herself and the child.

A general rule of thumb for incident reports should be to document anything that is beyond the “normal” daily routine for that child.

Competency

D The participant will demonstrate the ability to communicate within a group setting.
(Level 2)

WORKING ON A TEAM

You are a member of a team. A team is a group of people who share a common goal and work cooperatively with each other to achieve the goal. Teams are at their best when everyone is committed to reaching the goal, shares information and problem-solves together. The focus of your team is to help the child and family. They are the experts about their situation and in most cases they know what is best for them. The child and family should be setting the goals that all the team members will work towards achieving. Each person on the team will bring some kinds of expertise.

There may be clinical members on the team, i.e. a psychiatrist, physician, physical therapist and/or speech/language therapist. There may be teachers or a coach, and there may be natural supports or religious leaders. Members of the team may have different points of view about how to meet the goals. An important function of the team will be to listen to and understand all the different points of view and to support each other in meeting the child and family's goals.

DIFFERENT KINDS OF LEADERS

The team leader is responsible for guiding the other members in setting goals, developing, implementing and evaluating interventions. The leader of your team may shift depending upon the setting. In a meeting to review the ITP, the clinician or supervisor may assume a leadership role, at a PET meeting the Special Education Director might be the leader and in a case management meeting, the Case Manager may lead the team. You may be the team leader when you are teaching the child and family a new strategy or skill.

A good leader is able to support the relationships in the team and keep the focus on the task. There are three (3) basic styles of leadership:

- Autocratic – the leader uses her/his authority to make decisions
- Democratic – decision making is shared equally among member
- Laissez-faire – is "hands -off", the team makes its own decisions

Good leadership is flexible. It requires being able to look at a situation and

understand the best approach for working with the team or an individual on the team. Each of these styles is useful in a particular situation, for example:

- An autocratic approach might be used if the child is having difficulty managing his/her behavior. You direct the child to use a relaxation technique.
- A democratic approach could be used in most situations. This approach would support the child and family having a voice and a choice. You may ask the child which of the goals s/he wants to work on and what s/he wants to do.
- A laissez-faire approach might be used to encourage and empower the child and family. You support the child and/or family to write the agenda for a team meeting.

CHARACTERISTICS OF GOOD TEAM MEMBERS

To be a good team member you will need to develop a set of characteristics that will support the team's functions. Characteristics of a good team member include, but are not limited to:

- Working interdependently where the focus is on doing what needs to be done to reach the goal
- Freely sharing talents and ideas
- Disagreements are managed without doing damage to relationships
- Listening to each other
- Understanding each other
- Communicating respectfully with each other
- Treating each other respectfully
- Following the golden rule; each team member treats every other team member as they would like to be treated

DO	DON'T
◦ Contribute and share	◦ Withhold
◦ Listen	◦ Interrupt
◦ Seek feedback	◦ Reject feedback
◦ Treat others with respect	◦ Ridicule or attack
◦ Encourage others	◦ Dominate or control
◦ Commit to team goals	◦ Commit only to personal goals
◦ Ask for clarification	◦ Assume you know
◦ Clarify and summarize	◦ Refuse to clarify and summarize

HOW TEAMS WORK

There are many models that describe how teams or groups function. In one model, there are three (3) basic activities that a group must do. These are the:

- Task – the process or how the work gets done
- Topic – the specific item(s) that the team focuses on
- Relations – the interpersonal connections between the members.

In this model, all of the activities are interconnected. A team will move back and forth between these three activities. When the team agrees about each one, they will move forward and accomplish the goal.

In another model, there are four (4) phases. These are:

- Forming - when the members learn about each other and the goals
- Storming - when there is disagreement about how to process and who will assume what role
- Norming - when the team agrees upon the rules (stated and unstated) and talk about achieving the goal
- Performing - when the team is clear about the goals and works on accomplishing them

You may notice your team moving through these activities or phases. They are normal functions of any group. You should use supervision to gain an understanding of the role you play on the team and how you can best support everyone in achieving the goals.

COMMON ROLES

The common roles in a group generally fall into three (3) categories:

- Task
- Social
- Individual

Each role behaves in a certain way. Each can be beneficial to the group or they can distract from the group's ability to achieve the goal. Roles that are focused on the task and the relationship tend to be more productive. A role that has an individual focus tends to disrupt the group's ability to meet the goal.

The following behaviors can be observed:

- Task – tend to keep the attention on achieving the goal. Behaviors associated with this role are:
  - Getting the group to generate ideas
  - Explaining and showing the relationship between ideas
  - Stimulating and/or shifting the direction of discussion or activity
  - Tracking and evaluating information, keeping records and measuring progress
- Social – tend to support the relationships among the group members:
  - Encouraging the members to share ideas and keeping communication open
  - Compromising and harmonizing, moving the group to place that supports everyone
  - Following, accepting the groups ideas
  - Observing, keeping track of activity and offering feedback
- Individual – tend to put an individual's needs above that of the group:
  - Challenging or attacking other members
  - Resisting the focus of the group
  - Dominating by excessive or non productive interactions between members or talking
  - Seeking attention, for sympathy, disclosing information, asking for privileges

KEEP TALKING

Keeping the lines of communication open is essential for productive functioning of a team. All teams will experience conflict at different points during the process of working towards achieving the goal. Conflict offers an opportunity to learn more about each other; explore how the work has been getting done and identify new strategies for achieving the goal. The same process that is used to resolve conflict between individuals is applicable to resolving conflict in groups. The following strategies can help to support conflict resolution in a group:

- Slow things down – acknowledge the conflict and get the group members to take a deep breath, take a break, and schedule another meeting with a specific agenda.
- Create enough space for each member to fully state his/her position.
- Acknowledge each member's experience.
- Brainstorm solutions.
- Get consensus on the solution.

Competency

E The participant will demonstrate knowledge of nontraditional modes of communication.
(Level 1)

COMPLEX COMMUNICATION

Many of the children and parent(s) you work with will have normal hearing and will speak English. And sometimes, you will work with a child or parent who has difficulty communicating. There are many reasons for the communication challenges.

There are several types of complex communication. The obvious complexity is an inability to speak or hear. There are also non-obvious complexities such as partial hearing loss, a communication or cognitive disorder, language difference or a psychotic state. Communication complexities often present the people engaged in a conversation with challenges and sometimes limitations with what and how to convey information.

Sometimes complex communications require the use of an interpreter or communication device. The SB-BHP may encounter a variety of complex communication; these may be with the child, family member, natural support or member of the IEP/Treatment team. S/he will need to seek guidance from her/his supervisor about how to work with a complex communication. Speech and Language Pathologists make the evaluations for communication difficulties, and Audiologists evaluate hearing.

COMMUNICATION SOLUTIONS

You may work with a child or family member who is hearing impaired or has some type of difficulty with language. He/she will be able to assist the team in understanding forms of communication that have proven to be effective for them in the past.

Some people who are deaf use American Sign Language to communicate, while others read lips. If you interact with a deaf or hearing-impaired person in the course of your work, you should always attempt to communicate. Try to understand the person's needs and show a willingness to communicate. If you show discomfort or impatience, you may unintentionally cause a disrupted communication.

Some people will have little or no speech. This may be due to severe mental retardation, Autism, or physical problems. Resources that people might use to communicate are:

- Visual-Gestural Communication – using facial expressions and body movements to communicate; for example, pointing to food or frowning and shaking the head to show "no".
- Graphic Mode – using symbols, like drawing, photographs or objects
- Communication Devices – manual or electronic systems like Communication Boards, Books and Wallets or prerecorded messages or devices that the person can type messages on.

A child may experience a great deal of frustration if s/he cannot say what s/he needs or wants. Often when a child feels s/he is not understood, s/he will become angry. A question to keep in mind when dealing with a child who is angry is "Am I understanding what the child is trying to say to me?" or "Is the child having trouble saying what s/he needs or wants?"
Each child, no matter what his/her ability, will have a unique way of communicating. You will want to pay close attention to the child's style of communicating. This can include use of words, sounds, behaviors, gestures or special communication tools.

TIPS FOR COMMUNICATING WITH CHILDREN

- Pay attention. Look, listen and wait until the child is finished. Avoid rushing the child.
- Encourage the child to talk about his/her wants, needs, thoughts and feelings.
- Use language the child can understand.
- Ask open-ended questions.
- Make sure you know what the child is trying to tell you. Avoid assumptions.
- Offer choices and options.
- Accept the child's way of expressing his/her feelings. S/he is doing his/her best.
- Role model different strategies for expressing feelings.
- Keep it fun.
- Keep it short, simple and to the point.
- Share your feelings in an open, honest manner.
- Use "I" statements.

TIPS FOR COMMUNICATING WITH CHILDREN WITH HEARING IMPAIRMENTS

- Keep your face where the child can see it.
- Be relatively close to the child.
- Speak clearly and slowly.
- Use a normal tone of voice.
- Use a lot of facial expressions and body movements as cues.
- Rephrase or repeat.
- Avoid background noise.

TIPS FOR COMMUNICATING WITH AN INTERPRETER

- Speak to and look at the person you are talking to, not the interpreter.
- Keep your message clear and direct.
- Look at the person when s/he responds to you, not the interpreter.
- Check to see that what you said was understood. Ask an open-ended question, such as "What will you tell your mother about our visit?"
- Remember the interpreter relates everything you say. Avoid using third-person pronouns saying, "Tell him/her …" to the interpreter. You are having a conversation with the other person, not the interpreter.

TIPS FOR COMMUNICATING WITH CHILDREN WITH VISUAL IMPAIRMENTS

- Sit face to face and encourage eye contact.
- Identify yourself and what you are doing.
- Describe what will happen next.
- Talk about all of the details of the objects, people or activity.
- Use hearing and touch as cues.
- Be sure your words and tone of voice say what you mean to say.

TIPS FOR COMMUNICATING WITH CHILDREN WHO ARE NON-VERBAL

- Keep good eye contact.
- Identify the child's mode(s) of communication
- Learn what the child's signs/gestures mean.
- Keep the message simple and direct.
- Visually reinforce the topic (pictures, drawings, objects).
- Focus on action; show the child what you want.

- Let the parent and child teach you how to use his/her communication equipment.

TIPS FOR COMMUNICATING WITH CHILDREN WITH MOTOR IMPAIRMENTS

- Use your body position and eye contact in a manner that is most beneficial to the child.
- Pay attention to how the child moves his/her body and/or uses sounds. Subtle movements or sounds may be an attempt to communicate.
- Allow the child plenty of time to respond to you. Children who stutter or have difficulty forming words may stop talking if they feel rushed.
- Assume the child understands what is being said. Motor disabilities should not be linked to cognitive abilities.
- Offer choices and options.

Perfect communication is harmony between intellect, emotions, voice and body.

bhsi

BEHAVIORAL HEALTH SCIENCES INSTITUTE

7

Module 7 —

Principles of Behavior and

Instruction

Activities

Pre-Activity Discussion for Activity 1/Module 7

Talking Points:

What does behavior communicate?
What are some needs being expressed or purposes of defiant, disruptive or noncompliant behavior?

1. Ask the group their ideas about what behavior communicates.
2. On a white board write: "Needs Being Expressed or Purpose Of"
3. Instruct the group to brainstorm some of the needs being expressed or possible purposes of defiant, disruptive or noncompliant behavior.
   (Ask for a volunteer to write out responses if you prefer).
4. Review the list once it has been completed adding any additional information needed.
5. Ask the group to give you the most common needs or purposes for challenging behaviors they have seen so far in their work.
6. Discuss.
7. Lead into Activity 1/Module 7.

What's the point? To get the students thinking about the idea of behavior as a means for communication.

Activity 1:

Instructions:

1. Split the group by counting people off by 1, 2, 3 and 4.
2. Have the 1's, 2's 3's and 4's form into groups.
3. Hand out the worksheet, "Purpose, Need, Action"
4. Read through the worksheet questions with the group.
5. Explain that each group is to present a scenario and provide the information for numbers 1-4 on their paper. Direct the group to print or write as legibly as possible. The groups should discuss #5 without writing down their ideas.
6. Reconvene the group.

Instructor's Choice:

A. Redistribute the worksheets so each group has a scenario that wasn't written by them. Have the same groups disperse to discuss the scenario developed by another group. Have each group document their ideas for #5, "How can I positively support the child?" When the groups reconvene, have each group present the scenario they worked on and ideas they generated. Facilitate group responses eliciting other ideas members in the class may have.

OR

B. Read through a worksheet or have a group member read through their worksheet. At # 5, "How can I positively support the child?" illicit responses and facilitate dialogue. Review/discuss all worksheet scenarios.

The worksheet for this activity has the title: Purpose, Need, Action.
Instructions: Develop a scenario involving a disruptive behavior in the school setting. Complete #'s 1-4. Discuss # 5 but do not write down your ideas on the worksheet.

(The worksheet will state the following questions with sufficient room to respond for each question.)

1. What is your scenario? What is the child doing?
2. How is the environment impacting the child?
3. What is the purpose of the behavior?
4. What need is being met?
5. How can I positively support the child? What can I say, do or not do?

<u>What's the point?</u> To have the students dissect the purpose of behavior and problem solve different scenarios by sharing their interventions.

Purpose, Need, Action

Instructions: Develop a scenario involving a disruptive behavior in the school setting. With your group, complete # s 1 to 4. Please print or write legibly. Discuss # 5 but do not write down your ideas on your worksheet.

1. What is your scenario? What is the child doing?

2. Is the environment impacting the child? If so, how?

3. What is the purpose of the behavior?

4. What need is being met?

5. How can I positively support the child? What can I say, do or not do?

Activity 2:

WORKING WITH RESISTANCE

Resistance is a normal response to change. We tend to be most comfortable with things that are familiar. This also applies to behavior.

Truly and deeply understanding the many aspects of another person is a complex process and it takes a long time. Resistance will happen in many different ways. The following eight (8) strategies are just some of the ways you might handle resistance.

Instructions: Read each strategy about handling resistance to change. Circle approaches you use or would like to use. Is there an approach you use the most? Are there approaches here you absolutely don't like? Why? Do you approach your work differently? How?

Discuss your thoughts with a classmate/s.

- Start from where the child is. Use unconditional positive regard and avoid being personally invested in the outcome. Spend time listening to what the child is saying. Seek to understand the child's reason for resisting your help. For example, tell yourself that the child is doing the best s/he can at the moment; listen for the need the child is trying to meet.
- Find out what the child wants. Often times, finding a way to give the child what s/he wants can de-escalate a situation. When you use this strategy, make sure you avoid losing control and compromising your integrity. For example say to the child "Tell me what you want right now." Some of the questions you could ask yourself are:
    - Does what the child wants fit in with the treatment plan?
    - Would compromising de-escalate the situation?
    - Would the compromise violate a boundary?
    - Is there an alternative that would de-escalate the situation and not violate a boundary?
- Avoid power struggles. Look at all situations and find the "win-win" resolution. Power struggles usually occur when both people have a personal investment in the outcome. Find ways to resolve the situation so the child does not lose face. For example, describe the situation, "I see you like your book and you don't want to get ready for music class". Offer two (2) options that will help the child follow through "You can tell me when you're ready to line up or I can give you two (2) minutes to get ready".
- Stroke-stroke-lead. Before telling a child what to do, tell him/her two things that s/he does well. Children do not always know what they do well. They need adults to point out the things that they do well.
- Drop the bomb and walk away. Make your request, create some distance and wait for the child to comply. This allows the child some time to process the request. Some children need 20 – 30 seconds (or more) to process requests.
- Positive Reframe. Instead of saying what is wrong with the behavior, a statement can be made about what is right with the behavior. For example, a child is angry, yelling, and kicking his backpack around. Instead of saying, "Stop that yelling and kicking.", the BHP might say, "You're doing a great job letting me know how angry you are. Please tell me about it."
- Practice anger management. Help the child develop skills to handle frustration and anger in situations where there is little or no stress. Make a game out of practicing managing impulses. For

example, when you notice a child is getting angry you might ask him/her to take a deep breath, you might role-model taking a deep breath, you might ask the child if s/he feels hot or cold, or point out that the child is clenching his/her fists. You might ask the child to name the feeling in his/her stomach or you might invite the child to count to ten (10).

- SAMS – State goal/mission, Ask for cooperation, Mention the goal/mission again, Set the direction/limit. Allow enough time between each step to allow the child to process what is being said and asked.

What's the point? To have the students examine approaches that they have used for behavioral interventions, which ones that have worked and what they may want to try in the future.

Activity 3:

Instructions: In groups of 3-4, brainstorm ways of preventing some of the disruptive behaviors you see most in your positions.

Some of the considerations you may flesh out could be:

- Prevention at both the system and individual levels.
- Understanding the underlying impetus for the behavior.
- Identifying and building the necessary skills to make more appropriate choices.

- Specific techniques for helping a child.
- Positive reinforcement systems.
- Consequences.
- Unconditional Positive Regard.
- Strengths based language/attitude.

What's the point? Give the students a chance to think preventively with their interventions.

Activity 4:

Instructions:
Work with 1 or 2 partners. Try to each identify a challenging behavior for which you haven't mastered an intentional response (or at least one that isn't working very well for you). If you have been at this job for a long time and feel you've worked out a lot of the kinks, share with your partner(s) a challenging behavior that stumped you in the past and the approaches you developed to best deal with it.

What's the point? To have the students practice responding to behaviors in a more intentional way vs. instinctual way.

Activity 5:
Instructions:
Step One: Take a moment to generate a list of positive attributes of a child with whom you work.

Step Two: Generate another list for the behaviors you find most challenging.

Step Three: With a partner/s brainstorm and document a list of words, comments, gestures, signals or body language which convey unconditional positive regard.

Step Four: Reconvene as a group and share your ideas.

What's the point? To have the students practice the concept of unconditional positive regard.

bhsi

BEHAVIORAL HEALTH SCIENCES INSTITUTE

7

Module 7 —

Principles of Behavior and

Instruction

Content

Module 7 – Principles of Behavior and Instruction

Overview

Each School-Based Behavioral Health Professional (SB-BHP) needs to have a basic foundation in understanding, predicting, and managing behavior safely. This module is intended to prepare the SB-BHP to objectively observe behavior, teach appropriate behavioral skills and manage challenging behaviors safely.

Competencies:

A The participant will demonstrate the ability to objectively observe, and interpret the child's behavior.
(Level 2)

B The participant will demonstrate the ability to manage challenging behaviors and teach appropriate behavioral skills.
(Level 2)

C The participant will demonstrate the use of reinforcement, modeling, redirecting and other learning strategies in teaching behavioral skills.
(Level 2)

D The participant will demonstrate knowledge of strategies for assisting the child in networking with peers.

Competency

A The participant will demonstrate the ability to objectively observe, record, and interpret the child's behavior within the culture of the child's family.

(Level 2)

BEHAVIOR

Behavior is an observable action. Behaviors can be seen, heard, and felt. Behavior is both verbal and non-verbal. It can be a response to something in the environment or a response to a thought or a feeling. A behavior that is caused by a thought or feeling is more difficult to understand than a behavior that is caused by something you can identify in the environment. Behavior can be broken down into three areas:

- Motor – actions that are done by our bodies, i.e. walking, hitting, or eating.
- Cognitive/verbal – words and thoughts, i.e. speech, writing, problem solving or day dreaming.
- Physiological – automatic bodily functions, i.e. blinking, breathing or the heart beating

All behavior has a purpose. It can be predicated and is usually hard to change.

When you are working with a child you need to keep a dual focus. You need to be aware of your behavior and how it is impacting the child and you need to be observant of the child's behavior. Carefully observing behaviors can help you understand other people and yourself. You make assumptions about someone's attitudes, feelings, capabilities, and values based on what you observe. It is important to keep in mind that you are only making a hypothesis about what a behavior might mean. You need to explore your assumptions about a behavior. Exploring the meaning of a behavior builds relationships by increasing understanding.

Behaviors are positive and negative. It is often easier to see the problem behaviors in a child, but it is also more important to identify and reinforce the positive behaviors. A clear understanding of a child's positive behaviors will enable you to build on the child's strengths and reduce negative behaviors.

INFLUENCES ON BEHAVIOR

Behavior is influenced by genetic or inborn factors and by the environment. Genetic factors are:

- Physical traits, such as height, weight, gender or a medical condition that affects normal functioning

- Temperaments and talents, such as:
  - Level of physical activity
  - Determination and persistence
  - Extrovert/introvert
  - Predictability of behavior patterns
  - Mood and disposition
  - Ability to pay attention
  - Ability to adapt to change
  - Intensity of responsiveness
  - Sensory tolerance

Children who have 'difficult' behaviors often have temperaments that include:

- High or low levels of physical activity
- Difficulty attending to tasks
- Difficulty adapting to new situations and/or people
- Tendency to withdrawal
- Unpredictable behavior patterns
- Low sensory threshold
- Negative mood

- Organic factors can affect physical development and temperament, which in turn impacts behavior. Factors that influence behavior include:
  - Food allergies
  - Effects of alcohol and/or drugs on fetal development
  - Level of nutrition
  - Brain injury
  - Lead poisoning

Environmental factors such as places, circumstances or people that may affect behavior are:

- Physical environment – urban/suburban/rural Family environment – single parent/two-parent/blended family, communication style and values
- Cultural environment – race, socio-economic level, or religion

Family culture has a significant impact on behavior. Overall, parents want to do the best for their children. A family will consciously and unconsciously create a structure to support and nurture their children. All families have unique cultures that influence behavior. Some of these influences are:

- Manners, style of dress, codes of conduct
- Food preparation and eating habits
- Hygiene practices
- Openness to help from others
- Values about education, work and play

All genetic and environmental factors play an important role in the behaviors of the child and family. You will seek to understand the influences on the child and family. You will also explore, with them, the things that could change in their

environment to increase their opportunities for change and growth. You will work with them to set goals that build on their strengths.

BEHAVIOR IS LEARNED

Most behaviors are learned. Behaviors are learned through observation, imitation, and trial and error. Trial and error is affected by several variables:

- Unplanned consequence
- Planned consequence
- Structure environment that creates opportunity for experimentation

Some behaviors can result from the absence of learning. The absence of learning refers to a lack of exposure to a positive role model or an opportunity to learn. In situations where a child lacks a positive role model or opportunity to learn, the skills s/he learns are often inadequate for getting along in the world.

BEHAVIOR IS PURPOSEFUL AND PREDICTABLE

Behavior is purposeful and predictable. It can be understood as trying to meet a need/fulfill a function. It is important to understand the purpose or need for a behavior. Some of the questions you will want to ask yourself as you seek to understand a child's behavior are:

- What is the child doing?
- How is the environment impacting the child?
- What is the purpose?
- What need is being met?
- Could this need be met in other ways?
- What can I do to positively support the child?

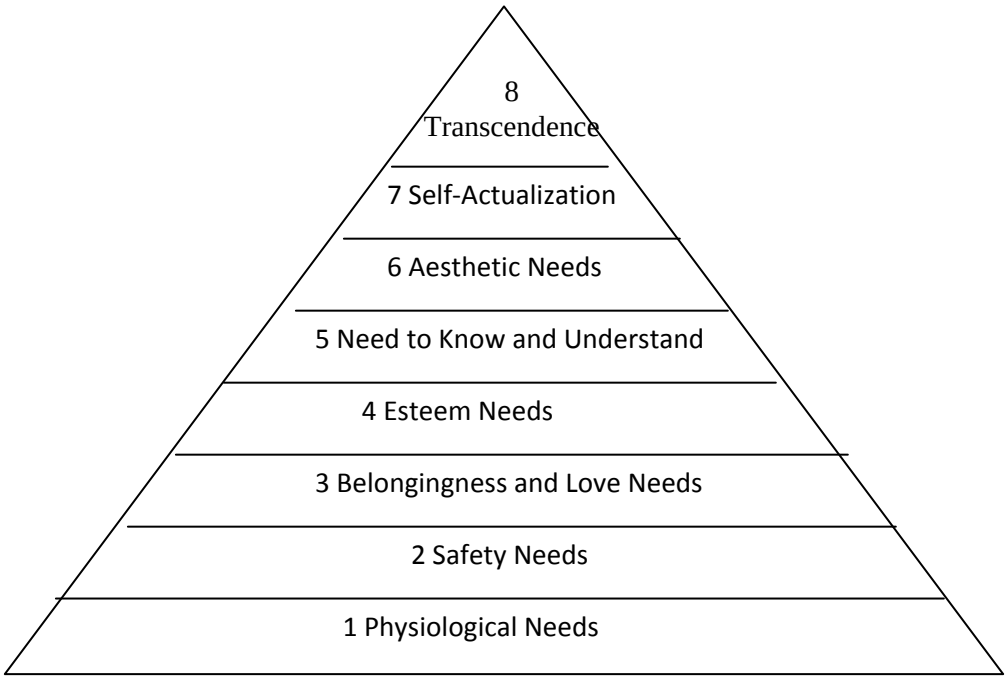
Some behaviors will be easy to understand and talk about with the child. Some behaviors will be very difficult to understand. It may take you a long time to get a clear understanding of the purpose of some behaviors. As you gain an understanding of the purpose of a behavior you will also begin to understand the meaning. Some of the reasons for a behavior might be to:

- Get attention or recognition from parents or adults
- Imitate
- Keep attention away from something that is uncomfortable
- Gain acceptance
- Release pent-up emotions.
- Seek justice
- Access (to a desired object/person)
- Escape

- Control

A child's behaviors can be seen as a way of getting a need met. Maslow's Hierarchy of Needs identifies eight (8) needs that motivate behavior. You will most likely be dealing with the first five (5) levels of need; the need for air, water, food and shelter; the need to be safe from harm; the need to receive and give love; the need to feel capable and respected and the need to know and explore.

MASLOW'S HIERARCHY OF NEEDS



In Motivation and Personality (1954) and Toward a Psychology of Being (1962), Abraham Maslow presented a theory that individuals have a hierarchy of needs. The basic needs must be satisfied before other needs can be met. For example, a person who does not have food or shelter does not seek to have his/her need to explore satisfied. The eight (8) needs are:

- Physiological: These are the basic needs for survival that include, but are not limited to: air, water, food, and shelter. When this level of need is threatened, the person's behavior is desperately motivated to meet them.
- Safety/security: Once basic survival needs are met, behavior is motivated by the need to be safe from harm. Any external or internal force that jeopardizes a sense of safety will be seen as a threat. These could be, but are not limited to: physical, emotional, sexual, and psychological.
- Belonging and Love: As survival and safety needs are meet, behavior is motivated by the need for connection. This involves the receiving and

giving of love and belonging. This need is important for continued procreation and the strength in numbers that occur with social functioning.

- Esteem: This need is motivated by the desire to achieve, to be competent, and to have self-respect and respect from others. This behavior leads to investment in self and a social group. As this need is satisfied the individual experiences feelings of self-confidence and of being valuable. When this need is frustrated, a person may feel inferior and worthless.
- Cognitive: Our desire to know and ask the question "why" motivates this level of behavior. The exploration of the world, ourselves, and the meaning of life can be pursued when prior levels of need are secure.
- Aesthetic: Culture, art, music, and design are all motivated by our need for symmetry and beauty. As any creature evolves beyond the basic levels of existence, the finer aspects of life become increasingly significant.
- Self-actualization: As life, sustenance, and belonging are secure we allow ourselves greater self-exploration. The resulting questions explore the very essence of our being, and strive for great fulfillment.
- Transcendence: The final stage of need satisfaction, as presented by Maslow, suggests a level of functioning that fully rises above survival and is focused on spiritual enlightenment and altruism.

When you understand the purpose and meaning of a behavior and have observed a pattern in the behavior, you can make predictions about what might influence that behavior. Objective observation of the behavior will help you predict what will increase or decrease a behavior. Using these observations as the basis for developing your intervention strategies will promote growth and positive change. Things that you will want to notice are:

- Where does the behavior happen?
- When does the behavior happen?
- Who is doing what when it happens?
- How often does it happen?
- What is the time of day?
- Who is in the room?
- What happened just before the behavior?
- What happened just after the behavior?
- How do be those around the child respond to the behavior?
- What is a typical outcome?

A formula that you might use to keep your focus on learning about and predicting the behavior is:

OBSERVING + UNDERSTANDING = PREDICTION

BEHAVIOR IS RESISTANT TO CHANGE

A well-established behavior or one that is meeting a need will be hard to change. Resistance is a normal part of the change process. A behavior that has meaning and is meeting a need is often difficult to change. The child will need to see how the new behavior will be meaningful and will meet his/her needs. Some of the reasons for resisting changing a behavior are:

- It successfully meets a need
- It support a child's view of the world
- It maintain a child's sense of safety and security
- A reluctance to give up the familiar for the unknown

WORKING WITH RESISTANCE

Resistance is a normal response to change. We tend to be most comfortable with things that are familiar. This also applies to behavior. You may notice the child and family resisting your help. You will want to try and understand the reasons for the resistance.

Working with resistance can give you an opportunity to gain a deeper understanding of the child and family. Truly and deeply understanding the many aspects of another person is a complex process and it takes a long time. Resistance will happen in many different ways, the following eight (8) strategies are just some of the ways you might handle resistance.

- Start from where the child is. Use unconditional positive regard and avoid being personally invested in the outcome. Spend time listening to what the child is saying. Seek to understand the child's reason for resisting your help. For example, tell yourself that the child is doing the best s/he can at the moment; listen for the need the child is trying to meet.
    - Find out what the child wants. Often times, finding a way to give the child what s/he wants can de-escalate a situation. When you use this strategy, make sure you avoid losing control and compromising your integrity. For example say to the child "Tell me what you want right now." Some of the questions you could ask yourself are:
    - Does what the child wants fit in with the treatment/habilitation plan?
    - Would compromising de-escalate the situation?

- Would the compromise violate a boundary?
- Is there an alternative that would de-escalate the situation and not violate a boundary?

- Avoid power struggles. Look at all situations and find the "win-win" resolution. Power struggles usually occur when both people have a personal investment in the outcome. Find ways to resolve the situation so the child does not lose face. For example, describe the situation, "You don't want to fasten your seat belt. Offer two (2) options that will help the child follow through "You can tell me when you're ready to fasten your seat belt or I can give you two (2) minutes to get ready to get your seat belt fastened.
- Stroke-stroke-lead. Before telling a child what to do, tell him/her two things that s/he does well. Children do not always know what they do well. They need adults to point out the things that they do well. For example, you might say to a child who is refusing to leave a store "You really like being in this store and you especially like looking at all the stuffed animals. Now we are going to head back to your house. We will come to the store tomorrow."
- Drop the bomb and walk away. Make your request, create some distance and wait for the child to comply. This allows the child some time to process the request. Some children need 20 – 30 seconds (or more) to process requests.

- Positive Reframe. Instead of saying what is wrong with the behavior, a statement can be made about what is right with the behavior. For example, a child is angry, yelling, and kicking his toys around. Instead of saying, "Stop that yelling and kicking things around", the SB-BHP might say, "You're doing a great job letting me know how angry you are. Please tell me about it."
- Practice anger management. Help the child develop skills to handle frustration and anger in situations where there is little or no stress. Make a game out of practicing managing impulses. For example, when you notice a child is getting angry you might ask him/her to take a deep breath, you might role-model taking a deep breath, you might ask the child if s/he feels hot or cold, or point out that the child is clenching his/her fists. You might ask the child to name the feeling in his/her stomach or you might invite the child to count to ten (10).
- SAMS – State goal/mission, Ask for cooperation, Mention the goal/mission again, Set the direction/limit. Allow enough time between each step to allow the child to process what is being said and asked.

BEHAVIOR AND SELF ESTEEM

There is a strong interaction between self-esteem and behavior. A positive sense of self results in positive behavior. In your work with the child, you will always want to attend to fostering positive self-esteem. Creating opportunities for success and encouragement, and emphasizing positive behaviors are some ways in which you can build self-esteem.

OBSERVING BEHAVIOR

As a SB-BHP you will have continual opportunities to observe the child closely, which will be of great help to the team. You will be gathering data that will help the team understand the complexities of the child's behavior. The information you provide to the team may help them make a diagnosis and develop a treatment plan and strategies for meeting the treatment goals.

SHIFTING YOUR FOCUS

There is a tendency to focus on the problem or what is going wrong. Although it is important to have an accurate understanding of the problem, it may be more important to understand the strengths that a person is already using to cope with it. A strength-based practice identifies, nurtures, elaborates, and builds on what works. Several assumptions guide strength-based practice:

- A person is already using his/her strengths and abilities to meet his/her challenges.
- As a person's positive traits are supported, it is more likely that s/he will act on them.* (adapted from Strength Based Perspective Training by Susan Casey LCSW)

Some of the ways you can identify strengths are:

- Look for exceptions. What is going on when the problem is not present?
- Explore inherent strengths, use the VIA survey for children and adults.
- Recognize physical traits, interests, talents, etc.
- Look for what creates motivation.
- Identify natural supports.

One way you can think about using strengths is to use the ROPES *

- R – knowing what Resources that are available and using them
- O – noticing Opportunities to create change
- P – keeping open to the Possibilities to what can be done/what can happen
- E – notice the Exceptions

- S – using and building on the Strengths
  * (adapted from Strength Based Perspective Training by Susan Casey LCSW)

MASTERING OBSERVATION

Observing, like listening and talking, is a skill that you need to master. In your observations of the child, you will be noticing specific aspects of a behavior(s), patterns of behavior and changes in the behavior. There is a wide range of elements that you should attend to. These include, but are not limited to:

- Physical appearance
- Health
- Level of activity and habits
- Cognitive functioning
- Emotional functioning
- Social functioning
- Interests and dislikes
- Behavior management
- Physical environment

You will want to notice behavior patterns. Patterns can be seen in daily routines, responses to stress, or transition times. They can be observed over the course of a day, week or longer, with a specific person, event or time. Understanding a pattern will help you to understand the potential functions of a behavior, as well as any triggers that may exist.

Another thing that you will want to pay attention to is change. First you will want to identify what is typical for the child. This will establish a 'baseline'. The baseline is used to measure progress or regression. Some of your baseline information may include how the child behaves around daily routines, his/her response to stress or transitions. When noting a change in behavior, it is important to identify the things in the environment that have changed and the things that have stayed the same. A change can signal achievement or be a 'red flag' (warning sign). Timely awareness of changes in behavior can be used to:

- Signal an opportunity to work on changing a behavior
- Notice coping skills, strengths and vulnerability
- Add to your overall understanding of the child
- Teach or practice a new skill
- This will help you understand some of the things that affect the child's behavior.

You will want to report all the changes you notice in a child to your supervisor. When reporting a change, it is best to be as clear and concise as possible. Some of the things you should include in your observation of a change are:

- Who was involved?
- What was different about the child's behavior?
- When the change occurred?
- What were the circumstances under which the change occurred?
- What are possible meanings or reasons for the change?

You will want to pay equal attention to the positive and negative behaviors of the child. You will want to notice and support positive changes in behaviors as well as point out things for the child to work on. All children behave in their own unique way. Some children will master new skills easily while other children will take two steps forward and one step back and others will have a growth spurt followed by a period of maintaining the status quo. Careful attention to the child's unique style of communicating with his/her behavior and supporting his/her way of handling change will keep the growth process moving forward.

Competency

B The participant will demonstrate the ability to manage challenging behaviors and teach appropriate behavior skills.
(Level 2)

CHALLENGING BEHAVIOR

Children who 'act out' are trying to tell us something about what they need. They are doing their very best. At times you may think that the child is intentionally trying to cause problems. S/he may be trying to cope with anxiety and stress, may be feeling afraid, may not have words for what they are feeling or they may be trying to get a need met. If you approach all challenging behaviors as the child's best attempt to communicate, it will help you maintain an attitude of empathy for the child.

You are an agent of change. The attitude you bring to your work will influence your ability to teach new skills to the child and family. Being able to have a positive focus, look for strengths, have respect and hope will create an atmosphere in which change can occur. It will also help you resolve the inevitable problems or conflicts that will arise.

Some of the challenging behaviors that you will face can affect your professional boundaries. You will need to maintain your professional boundaries at all times. Sometimes there will be a delicate balance between your feelings of responsibility to the child and your responsibility to the school/agency, establishing a connection with the child and adhering to the school/agency policies.

Your professional and personal boundaries might be challenged in different ways. You may personally identify with the child and family's struggle. Alternatively, you could be getting a personal need met or be experiencing burn-out.

SELF-OBSERVATION

Self-observation is a key factor in your ability to help a child learn how to manage his/her behavior. It will help you move away from your instinctual ways of responding and move towards intentional responses.

Your behavior, like the child's, is influenced by many things. These include, but are not limited to: your fundamental values, your conscious and unconscious expectations, your style and your approach to problems. Your work will become

stressful from time to time and you will want to pay attention to your thoughts and feelings during the stressful times. Some of the things you will want to be aware of are the emotions you experience when there is a crisis; the ways in which you tend to automatically respond (fight, flight or freeze), things that you feel sensitive about (your "hot-buttons"), and how you express strong feelings like anger and sadness.

Developing an awareness of yourself will enable you to use strategies to interrupt a crisis phase and help the child learn and grow. In *Working with Children – Effective Communication Through Self-Awareness*, Dana Lewis writes "It is not the fact of anger that counts so much as how we express it in the presence of kids; what precedes it and what follows it … If you deny the existence of your own anger, you may be heading for problems."

Things that you can do to increase your awareness/self-observation are:

- Develop and learn how to use an observing eye and ear.
- Know what your response are to stress, surprise, compliments, and criticism
- Be emotionally and intellectually honest – having strong feelings, judgments and critical thoughts is normal. The more honesty you have about difficult feelings and thoughts, the more control you will have over them.
- Know the positive and negative experiences that have an impact on you.

Keeping cool and focused during times of high stress or crisis takes practice. Keep the following questions in mind:

- What are my emotions now? Acknowledging your feeling is the first step in managing behavior and communicating clearly with the child
- What is the child expressing? Identify the need the child is trying to meet. Seeing the situation from his/her point of view will help you respond in an effective manner.
- How is the environment affecting the child? Notice if there is something you can change to help reduce the stress.
- How can I best respond? The focus of your response should be on keeping the child safe, physically and emotionally and then helping him/her get his/her need met.

You will want to keep control over your emotions and your instincts. Using stress reduction techniques, identifying your feelings, and expressing them in an appropriate way, at an appropriate time, will keep you in control of your emotions and allow you to role model healthy coping skills. Understanding how you tend to

respond in a crisis is essential to controlling your instincts. You are responsible for creating a safe environment for the child. How you handle your emotions has a direct effect on the child's feelings of safety. It may be helpful to imagine a possible crisis situation and how you would respond and how your response might impact a child.

Self-awareness is also important for effective use of self. You bring your life experiences, interests, talents, knowledge and skills to your work. Some strategies for conscious use of self are:

- Be thoughtful about personal disclosure – if you feel like there is something you want to share, check it out with your supervisor.
- Be willing to respectfully express your feelings.
- Be willing to acknowledge mistakes.
- Ensure that all your actions are in the best interest of the child.

MANAGING BEHAVIOR THROUGH DISCIPLINE

According to The New Merriam – Webster Dictionary the verb *discipline* can mean, "To train or develop by instruction and exercise especially in self-control". The word has its origins in the Latin "disciplina" which means teaching or learning. A great deal of your work will involve the instruction and practice of behavior management skills such as impulse control, stress reduction, and problem solving. It is important to see discipline as a positive process and not a punishing one. As the child gains control over his/her behavior, self-esteem is increased.

SHAPING BEHAVIOR

Shaping behaviors through reinforcement is a well established method for teaching new skills and/or changing behavior. It involves identifying a skill or behavior, called the target, which the child will learn. When the child performs the target behavior, s/he is given a reinforcement (reward).

There are formal and informal methods of shaping behavior through reinforcement. You may be part of a structured reinforcement system developed by the team which will require you to interact with the child in a specific manner. You will also need to understand how to make use of informal reinforcement whenever you notice the child performing the desired behavior or skill.

In a positive reinforcement system, when the child performs the target behavior s/he is given something s/he wants (a desired object or item, attention, social praise, etc.). In a negative reinforcement system, an unpleasant stimulus is

withdrawn when the target behavior is performed. The intent of a positive or negative reinforcement system is for the child to repeat the behavior in order to receive additional reinforcers and thereby learning a behavior.

There are basically two goals in a behavioral reinforcement system. The short-term goal is to help the child learn a new skill. The long-term goal is for that skill to become part of the child's behavioral repertoire.

Behavioral reinforcement systems need to be carefully developed by a team of experts. Careful attention must be paid to reinforcing the desired target behavior and not some unintended one.

- The behavior must be realistic, within the child's ability to achieve.
- The desired behavior must be clearly identified.
- Everyone involved agrees to use the reinforcement system.
- Consistency is critical for success:
    - Behavior must be observable.
    - Reinforcement system must be manageable.
    - The reward is given immediately after the target is observed.
    - All adults involved must cooperate and maintain consistency.
- The reinforcement system must fit into the child's environment.
- Pay attention to unexpected results.
- Rewards should be reviewed over time to determine ongoing suitably.

Choosing the correct reward is important. It needs to be something that is important to the child and is easy to manage. Some types of reinforcement that might be used are:

- Praise – is a positive statement made about successful behavior.
- Encouragement – is a social reward that works with a child who wants to please; it is used while the child is trying to do something – regardless of the results.
- Non-verbal techniques – these reinforcers are easy to use; they build relationships and they are powerful. They include: a smile, wink, nod of approval, applause, thumbs up, ruffling of hair, pat on the back, whistle, shaking hands, high five.
- Privileges – are opportunities for independence that are granted when the child has demonstrated capability and trustworthiness.
- Material rewards – are items (food, objects) or activities.
- Positive peer reinforcement – consists of praise and encouragement from peers or siblings.

In The Skillful Teacher, Saphier and Glover discuss the theory and methods of reinforcement. The following is adapted from their work.

- Behavior has meaning. All behavior, whether it is acceptable or unacceptable is meeting a need, it has a purpose. In terms of reinforcement systems, the need being met by the behavior is called the "payoff".
- Most of the time the child is unaware of the "payoff" that s/he gets for the behavior.
- The team needs to figure out what the "payoffs" are for the child and identify rewards.
- A place and time when the positive reinforcement system will be used is identified.
- A decrease in the inappropriate behavior is a sign that a new behavior is being learned.
- As the child increases the frequency of the appropriate behavior, the external reward can be reduced.
- When the new behavior becomes internalized – automatic, the child has found a new "payoff".

PRINCIPLES OF REINFORCEMENT:

The successful use of a positive reinforcement system to learning a new skill can be a highly effectively motivator.

- Observe the child and identify the ways in which s/he is doing the target behavior and when s/he is not.
- Document what the child is doing that is different from the target.
- Review the information with the team to identify what the "payoff" is for not doing the target behavior.
- Brainstorm with the team what rewards could be substituted as the "payoff" for the child when s/he performs the target behavior.
- As often as possible include the child in deciding what reinforcer will be used.
- Design a structure for reinforcing the target behavior.
- What will the child need to do in order to get the reward?
- How frequently will the reinforcer be given?
- Who gives it?
- As the target behavior is achieved, how is the reward reduced?
- Make sure that the entire team [especially the child and parent(s)] is aware of the target behavior and the reinforcement system.

PRINCIPLES OF RESPONSE:

- Give the reward as soon as the target behavior occurs.
- Start giving the reward each time the target behavior occurs, this is continuous reinforcement. When the child can do the target behavior with continuous reinforcement, increase the number of responses required. This helps the target behavior to become internalized. Over time you will continue to fade the level of reinforcement until the behavior occurs naturally without reinforcement.
- Introduce other management techniques such as planned ignoring, fines, logical consequences, and redirection as replacements for the reward.
- If the program does not achieve the desired results, reevaluate the effectiveness of the reinforcers; take another look at the "payoffs" the child was getting.
- Introduce social reinforcers (such as a smile or verbal praise) in connection with other more concrete reinforcers (usually something edible, an activity the child enjoys or a material object).
- Check the child's level of internalization by decreasing the social reinforcers. If the child can't perform the target behavior without the social reinforcer, start using them again.
- Remember to work with your team to make decisions about changes to the reinforcement system.
- Be sure to communicate the decisions made by the team to all the team members, including the child and the parent(s).

PRINCIPLES OF MANAGEMENT OF A REINFORCEMENT SYSTEM

- The team needs to agree to use the reinforcement system.
- Consistent use of the system is essential for its success.
- The rewards must be affordable and readily available. They can come in the form of food, activities or material possessions.
- Everyone needs to be trained to make observations and chart progress.
- Child and parent(s) need to participate in the process of developing and implementing reinforcement systems.
- Child and parent(s) need to be kept informed of progress and/or problems with the system.

NATURAL CONSEQUENCES

A natural consequence is a normal result that follows a problematic behavior. It can provide a powerful influence on changing behavior. Natural consequences can be hard to identify at times. However, when they are known, they can immediately show the negative effects of behaviors. Using natural consequences preserves dignity, increases internal controls, and increases motivation. Natural consequences that can cause harm should not be used. Examples of natural consequences are:

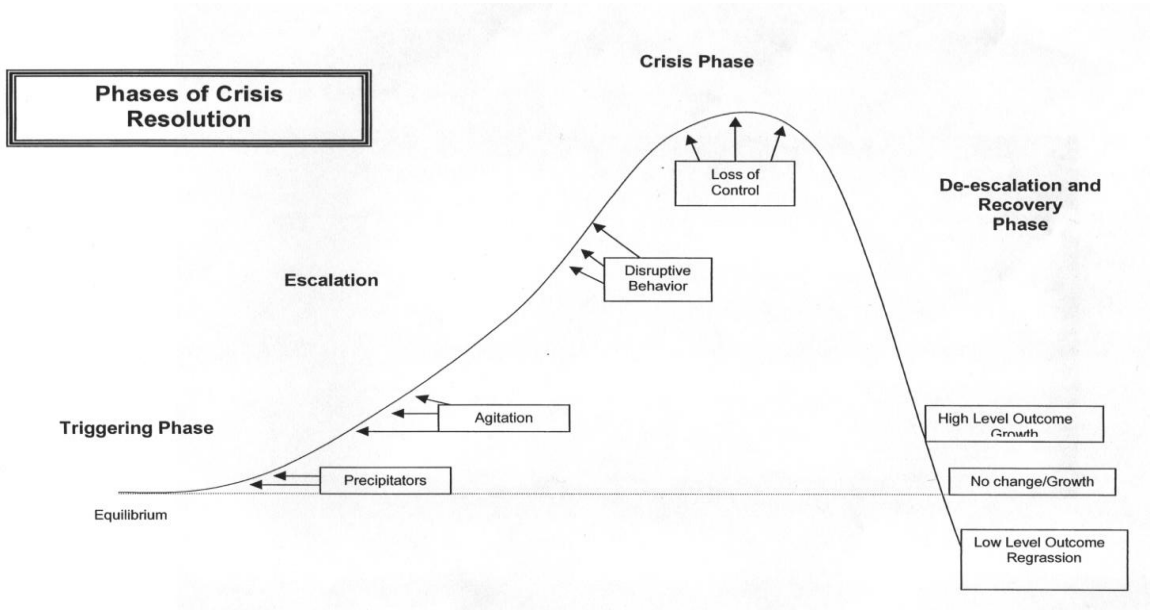
- Immediate social repercussions (a child who doesn't wait his turn on the playground is not asked to play at the next recess).
- Physical discomfort (refusing to wear a coat in the rain results in being cold and wet).
- Immediate loss of something important (repeated refusal to put a bike away results in the bike being stolen or unusable).

PUNISHMENT

Punishment is controlling and often designed to get immediate compliance at the expense of long-term gains. It can damage self-esteem and create anxiety and anger. Punishment is often a reflection of the adult's frustration and anger and is not a particularly useful teaching tool. Any use of punishment must be approved by the team. The use of punishment could be seen as abuse or neglect of the child. You are a mandated reporter and can be held criminally responsible for participating in or neglecting to report abuse or neglect.

Your aim is to make the best effort to help a child successfully manage his/her behavior. Despite your best efforts with the child, a situation may rise to the level of a crisis. Most crises are similar in the way they develop. The ability to identify these phases will help you to predict how a situation will play out, and intervene early to prevent a full blown crisis. There are four phases that a child or adult will go through during a crisis: Triggering, Escalation, Crisis, and De-escalation/Recovery. (Adapted from "Therapeutic Crisis Intervention", Budlong, Holden and Mooney, 1991)

PHASES OF CRISIS INTERVENTION



- Triggering or agitation phase – this stage is the beginning of frustration and irritation. The precipitant can be an external event that may or may not be obvious and observable. The child might be able to engage in problem solving or other containment strategies. This depends on the intensity of the underlying emotion. The more intense the emotion, the quicker the child will move to the next phase.
- Escalation phase – there is an increase in frustration and agitation. The behavior becomes more disruptive and volatile. The child is not able to talk about problem solving and s/he is less rational. Indignant yelling, pouting, withdrawing, challenging comments, or an increase in body activity are signs of escalation. A common response that will move the situation into a crisis is getting physically close to the child.
- Crisis – the child has lost control and is acting in a manner that is disruptive to others. S/he is no longer able to make rational decisions and there is no regard for the safety of him/herself or others. What caused the event is no longer relevant. The child is overwhelmed with emotion. Safety and de-escalation is the focus of the interaction. All stimulations should be kept to a minimum.
- Recovery – this can be a delicate phase, in which re-escalation can easily occur. The increased escalation and sudden emotional volatility are difficult

to predict. Moving too quickly can cause a sudden re-escalation. The child is often physically and emotionally exhausted and vulnerable to feelings of embarrassment or shame. The early part of the recovery phase is not a time to talk about what happened. The child needs time to calm down.

THREE POSSIBLE OUTCOMES

There are three possible outcomes to a crisis, Low Level, No Change, or High Level. How you resolve a crisis will impact the quality of your relationship with the child. There are three levels at which a crisis can be resolved:

- Low level – the child is hurt emotionally or physically. The child is not connected to you and your relationship has diminished. The child's ability to handle future stress has decreased.
- No change – the child does not learn from the event and may repeat his/her behavior in the future. You control the crisis but cannot talk about the reason and your relationship is most likely maintained.
- Higher level – the child is supported and regains self-control. You talk about the event and the child learns from the event. S/he has increased his/her ability to handle stress.

A crisis that involves extreme, out of control behavior can be unsettling even to a seasoned professional. It can be helpful to find way to prepare yourself for crisis situation. Some things you can do in a crisis are:

- Attend to safety – let the child know his/her safety is the primary concern and keep the environment safe. Some of the things to keep in mind are:
  - What are the needs of the child?
  - How are others responding to the crisis?
  - Know where the potential hazards are.
  - Know where the exits are and do not block them.
  - Call for support if possible.
  - Engage with the child as little as possible while s/he is irrational.
- Don't panic – rely on stress reduction strategies such as deep breathing, staying focused on regaining stability. You need to stay in control of your feelings.
- Start with using a calm voice to redirect or distract the child
- Let the child know you see that s/he is having a strong feeling. Use simple, clear statements.
- Pick your battles wisely; helping the child stay in control is more important than making a point.
- Use physical restraint only to protect the child or another person from imminent risk of harm. Physical restraints should only be implemented by

trained personnel and must be incompliance with the school/agency's policies and DOE regulations.

- Avoid making promises that can't be kept; a common trap is to desperately want the crisis to end and make a promise that can't be kept. This will lead to disappointment and can result in re-escalating the situation.
- Keep control over your feelings. It is normal for the stress of a crisis to stir up strong emotions. You will likely have strong emotional responses to a child's out-of-control behavior. Strategies for managing strong feelings such as anger include, but are not limited to:
    - Being aware of your anger, knowing when you feel angry, avoiding reacting automatically and using 'I' statements. An inability to acknowledge your anger can result in non-therapeutic reactions.
    - Being aware of your sensitivities, knowing what "pushes your buttons" and being prepared with a response when one is pushed. "Button-pushing" is a skill that many children are adept at. They have a keen sense about areas of sensitivity and often try to get a reaction during times of crisis. Pushing another person's button takes the focus off the child and the discomfort s/he is feeling.
    - Keeping a healthy distance. The child may need physical and emotional space to regain control. And you too may need to distance yourself emotionally. Focusing on taking a deep breath can give you some emotional distance
    - Understanding the crisis cycle. The child is experiencing an increase in stress and needs you to help him/her regain control. Your reaction will either increase or decrease the child's stress.
    - Be willing to learn from your mistakes. You will make mistakes, and unintentionally get caught in and escalate the crisis cycle from time to time. The more experience and knowledge you have about the nature of crisis and your response to it, the more adept you will be at handling a crisis.

CRISIS INTERVENTION - DO'S AND DON'TS

DO

- Take your time. Avoid acting impulsively.
- Try to isolate the person if possible.
- Ask for help.
- Try to establish a personal rapport, even if the person is a stranger. Give your name. Ask his/her name.
- Stay in touch with the part of you that is caring.
- Offer statements of understanding.
- Maintain a balance.
- Speak softly, slowly and simply.
- When you do not know what to do, go slowly.

DON'T

- The child's unhappiness is his/her own. Do not attempt to take it away, but help the child recognize its cause.
- Do less rather than more.
- Don't respond too quickly.
- Do not give people choices that are not theirs to make.
- Do not confuse the child's needs or problems with your own.
- Do not try to physically intervene with a hostile child.
- Recognize your limits.
- Don't use inflammatory words like "must", "should", or name calling.
- Do not try to resolve the problem by minimizing it. Acknowledge the seriousness of the child's feelings, no matter how trivial it seems to you.

MANAGING PROVOCATIVE BEHAVIOR

There might be situations in which a child behaves aggressively toward you. The child might bite you, pull your hair or grab your arm. It will be important for you to manage your impulses and to stay calm. You should be familiar with your school/agency's policy on physical interventions. Also, you should discuss strategies for managing aggressive behaviors with your supervisor.

A simple mantra for a crisis situation:

BREATHE **THINK** **SAFETY**

ANTICIPATE

Anticipating is a function, along with Containing and Resolving, of good discipline. The first function of a good discipline strategy is to create a way in which you can anticipate potential behavior problems. A structure will allow you to plan ways of preventing acting out behaviors and teaching behavior management skills.

Children need a safe, nurturing environment. Children are more capable of growing, learning, and developing an understanding of themselves through contact with, and responses from, adults who demonstrate an investment in their well-being. Nancy Cotton describes many of the qualities talked about so far that support the "person that we all hope to be". Other qualities that she refers to are:

- Energy – Change is physically and emotionally draining
- Resiliency – To bounce back, to try something different to be
- Cooperation – To cooperate with parent(s) in the best interest of the child
- Intellectual curiosity – asking 'why' and 'how'
- Playfulness – Children learn through play; use fun and humor in constructive ways.

She also aptly states "… that none of us reflects all these qualities all of the time in their most mature and creative form." (Adapted from Lessons from the Lion's Den, Nancy Cotton, 1993; Therapeutic Crisis Intervention, Budlong, Holden and Mooney, 1991).

You need to have a consistent way of working with the child that will create safety. In a safe and nurturing environment, the adults provide the following four things:

- Structure
- Routine
- Rules
- Positive Approach

Structure is imposed by adult supervision. All children need some degree of adult supervision. The amount varies according to age, personality, developmental level and behavioral needs of the child. Some forms of supervision are:

- One-on-one support
- Eyesight supervision
- Checking in

- Pre-approved itineraries
- Notebook or telephone communication between adults

Routine is the regular schedule of activities, or steps within an activity. Routines help to promote understanding and establish expectations. A child feels safe when s/he knows what to expect.

Rules that work and make sense can contribute to building a safe environment. You may be asked to help the team develop a set of rules which can then be used by the child to determine what is expected in various situations. Rules and principles are not the same. Most rules are built on principles, but principles tend to be general statements that are not clearly understood or enforceable. "Do unto others as you would have them do unto you" is a principle that can be explained to children and can be the source of a rule or two but in and of itself, it is too general to be useful as a rule.

Guidelines for developing rules are:

- Rules should be clear and concise.
- Rules should be positively stated.
- Rules should serve a clear purpose.
- Rules should include the consequence for breaking them.
- Rules should be explained to children before being put into place.
- Rules should be as few in number as possible.
- Rules are often most effective when made with the child's input.
- Rules should be frequently reviewed and revised.
- Rules should be consistent.
- Write the rules down.

A **Positive approach** has three functions; Protect, Engage and Teach.* As a protector for the child you will be keeping the child safe and structuring his/her environment for maximum growth. You will teach the child new skills and new ways of looking at him/herself and others. You model behavior and attitudes for the child and family. *(adapted from "Protecting the Child in Residential Group Care", Ohio Association of Child Caring Agencies, Inc.).

- Environments that PROTECT create security and are developmentally appropriate for the child. The physical environment is structured to minimize frustration, promote independence, and encourage progress such as a:
  - Specific private space for each child and adult

- "Time-out" space
- Place to display schedules and/or behavior charts
- Place to display the child's accomplishments (artwork, schoolwork, awards and family photos)
- Reduced disorganization and accessibility to objects that could be used as weapons in volatile situations
- Stimulation levels are manageable and within the child's capabilities for self-control. For example:
  - Introduce quiet activities if the child has difficulty with too much action.
  - Introduce constructive activities
  - Noise and light can have a stimulating effect on a child.
- Expectations are expressed directly and clearly. For example:
  - Inform the child about what s/he can expect. Predict changes and transitions to allow the child time to adjust.
  - Keep things simple. Rules, routines, and procedures should be easily understood. Explanations should be brief and to the point.

- Environments that ENGAGE develop a working alliance that promotes interest, involvement, curiosity, and interaction.
  - Encourage – show and express confidence that the child can meet the expectations. Children often lack the confidence and self-esteem that adults take for granted.
  - Appreciate what the child does. Look for and inform the child of every bit of progress that s/he is making. Acknowledge and understand that the work the child is doing is difficult.
  - Listen to the child express his/her thoughts and feelings. Invite comments and be receptive to the child's opinion.
  - Provide for as much independence as possible. A child should make decisions and have some control over his/her life situation.
  - Offer choices. This is a way of providing independence in a simplified manner. If the options are made clear to a child, s/he may feel empowered.
  - Break routines and bend rules on occasions. This provides a welcome relief from monotony and can help the child feel s/he is more important than enforcing the routines and rules.
  - Role-Play including reversal of roles. Practice the situations the child may encounter and have him/her develop appropriate responses. Repeated rehearsals can give a child the confidence to try out some new behaviors.

- Respect the child's fantasies. Respond to wishes as valid expressions of feelings rather than demands or opposition. Fantasy play often serves the purpose of life practice, respite from stress, or entertainment.
- Use humor. The careful use of humor can defuse a situation and alleviate conflict. It can put in perspective aspects of life that are often taken too seriously.
- Present requests in ways that connect to the child's interests. Linking what the child is interested in or likes, with what s/he needs to do often increases the child's cooperation.
- A game-like approach is often useful with a child. This can engage his/her imagination and relieve feelings of being controlled.
- Use writing for some communications. Children who can read may occasionally appreciate a written note.

- Environments that TEACH provide information and experiences to help the child have a better understanding of him/herself.
  - Explain the reasons for the rules and limits. Understanding is the goal, it leads to more cooperation.
  - Present limits impersonally. This emphasizes the need for compliance and takes the focus off the child's behaviors.
  - Expressing feelings honestly in a non-threatening manner, reduces misunderstandings.
  - Teach anger management to the child. The use of words is preferred to physical aggression. Acceptable venting and constructive verbal expression should be encouraged. For the child who needs to express him/herself physically, demonstrate appropriate physical expressions of anger, i.e., stomping feet.
  - Avoid or disengage from unnecessary arguments. Keep in check the urge to be "right". Use various techniques: concede a point, shrug your shoulders, explore the importance of the conflict, or excuse yourself; and then return to "revisit" the scene.
  - Use a problem solving approach to reduce the emotional tension of a personal struggle. It helps the child feel valued. It teaches constructive thinking rather than reacting emotionally. It can resolve things in a satisfactory and enduring manner.

CONTAIN

The second function of good discipline is containing or managing challenging behaviors in a way that does not cause things to get out of control. Situations will

occur in which the child is unable to manage his/her behaviors. You will need to help him/her stay in control of his/her feelings and manage his/her behavior.

There are no responses and/or consequences that are consistently effective for all children in all situations. In fact, the same response may not be effective for the same child as s/he proceeds through different stages of development. Responses should be based on the child's history and need, developmental level, and the contextual variables – the influences on the situation.

There is a continuum of behavior management techniques that you can use to contain behavior. These include limit setting and a hierarchy of behavior management techniques that range from the least restrictive to the most restrictive.

GUIDELINES FOR LIMIT SETTING

Setting limits is a strategy you can use to help the child understand the rules, expectations of appropriate behavior, and the consequences. Limit setting offers the child an opportunity to recognize what s/he is doing and to change their behavior. The following steps are important in effective limit setting:
Communicate all expectations, predictions, and consequences clearly and accurately.

- Make sure the child understands what is expected and what will happen if s/he does not comply.
- Appreciate what the child is already doing well.
- Maintain a teaching attitude.
- Follow through with predictions and consequences.
- Re-evaluate and change plans if the expectations are inappropriate.
- Acknowledge mistakes and apologize.

Understanding a child's behavioral patterns and the warning signs that the child is feeling stress will help you to de-escalate most behaviors with the least restrictive technique. Some common signs of stress you might see include, but are not limited to: thumb sucking, baby talk, nail biting, stuttering, tattling, anger, anxiety, detachment or withdrawal.

HIERARCHY OF BEHAVIOR MANAGEMENT

Hierarchy of behavior management techniques move from the least to the most restrictive. All attempts to manage behavior should begin with the least restrictive.

- LEAST RESTRICTIVE types of behavior management techniques include:

- Creating space – increasing the physical distance between you and the child and reducing demands on the child. Staying within a safe distance and supporting the child to take some deep breaths can reduce stress.
- Non-verbal cues – can be a glance, facial expression, a movement of one's hand, or a physical touch. These can be effective when you anticipate something may happen or is just starting to happen. Use a tone of voice that fits the situation. Sometimes it will be a soft and personal tone, other times it will be a loud and direct tone. A soft voice can help to calm a child or interrupt escalating behavior because the child must quiet him/herself in order to hear what is being said. A loud and direct voice can also interrupt escalating behaviors by focusing the child's energy on the speaker's request.
- Planned ignoring – you can avoid being drawn into a situation and still watch and listen to how things are developing. Simply having a watchful eye and creating space can resolve a situation.
- Prompting – you may signal the child to either begin a desired behavior or to stop an inappropriate action. It can be done verbally or non-verbally. It is a pleasant reminder that is offered as privately as possible in a calm, non-critical manner; a prompt should be given once or twice and enough time should be allowed for the child to process and respond to the prompt.
- Redirection – you present the child with something else to do, say or think. Switching the child's attention can de-escalate the situation and help the child maintain control.
- Application of a behavior chart – many children respond positively to a chart that shows what is expected and tracks success with stickers, stars or by earning points. Pointing out the chart to the child can redirect and/or motivate him/her to stay in control.
- Affection – When the child is having difficulty, you needs to look past the behavior to determine the need the behavior is aiming to meet. Sometimes, insecurity, fear or anger may be the source. Showing care and affection for the child may help him/her cope. Affection can be verbal or non-verbal, depending on the need of the child. Always let a child know that you are going to touch him/her and make sure you have permission.

- MODERATELY RESTRICTIVE methods are used when the above techniques are not effective. You need to gage the time s/he will use with any of these techniques and plan ahead. These include:
  - Directive statements – that provide the child with clear and concise

directions about what the child needs to do to prevent the situation from escalating. A directive statement tells the child in specific terms what is expected.
    - Change in venue – where the intent is to change the environment and eliminate or reduce the stimuli that may be fueling the escalation.
    - Silent functioning – where the intent is for the child to continue the current activity for a set amount of time without talking. This provides the child with an opportunity to reflect on his/her behavior and use his/her own skills to contain the behavior.

- MOST RESTRICTIVE techniques are the most intrusive and should be used in situations where there is a potential for the child to harm him/herself or others.
    - Eyesight supervision –you closely observe or provide a different activity for the child. The child is to remain within eyesight and close to you.
    - Physical removal – If a child is not responding to verbal requests, you may need to help him/her to leave the situation. You might take the child by the hand or place a hand on the child's shoulder or elbow and direct him/her to another place. Any time you are need to use "hands on" you should tell the child what you are going to do.
    - Disciplinary measures – this may include the denial of activities or privileges. This should be used sparingly.
    - Therapeutic holding – there may be situations in which it is necessary to hold the child in order to prevent him/her from harming him/herself or others, or to protect property. This strategy is only used as directed by school/agency policy and requires being certified in a recognized therapeutic holding technique such as NAPPI, MANDT, TCI, etc.

RESOLVE

Resolving is the third function of good discipline. Despite a solid structure and your best efforts to contain a child, s/he may become out of control. When this happens, it is important to review what happened after everything has calmed down.

Handling an out of control child can have an effect on your working alliance. You will want to make sure that you re-establish a good connection with the child. One method you can use is to get a clear understanding of the child's experience. You will want to understand what happened from her/his point of view. You should be prepared to acknowledge any mistakes you may have made.

Many of the children you work with do not have the internal organization, or in some cases, the external structures to allow them to process today's problem tomorrow. Developmentally, they live in the moment and when that moment is gone, it is not retrievable as a learning tool. If the child is going to learn from the problem, s/he will have to explore things now.

Utilizing this teachable moment will allow you to first see the incident from the child's perspective, and then help him/her see the connections between his/her feelings and his/her behavior. Finally, you will help the child develop a plan or strategy in an effort to become responsible for his actions.

LIFE SPACE INTERVIEW

The Life Space Interview (LSI) * is a technique for helping the child make sense of the situation. Together you and the child discuss his/her feelings and behaviors, the choices s/he made, why s/he made them, and other choices s/he could have made. The LSI allows you and the child to learn from the situation in a supportive and non-judgmental way. The LSI promotes Higher Level Outcomes. *(adapted from Budlong, Holden and Mooney, "Therapeutic Crisis Intervention", 1991).

Fritz Redl and David Wineman introduced the Life Space Interview (LSI) as a result of their work with aggressive, delinquent youth at Pioneer House. Redl and Wineman used the LSI as a way to help overwhelmed and under-coping youths manage life events. Redl referred to the LSI as "the clinical exploration of life events". While the homes in which you will be working are not truly "treatment environments", the principles of the LSI are transferable. These principles can provide both you and the child's parents with a structured process for dealing with the troubling events that regularly occur in the lives of children. By definition, a LSI takes place in the child's natural environment and uses the unfolding incident as a teachable moment.

The LSI is defined as a structured, therapeutic interview that is intended to help the child learn from the events in his/her life in order to makes changes in behavior.

- Takes place within the setting, events, and times where the child lives (his/her "life space")
- Gives the child an opportunity to learn about his/her and others' behavior. For example, the child might be asked "What do you think made you do that?" and "How did the other person respond?"
- Is supportive, non-blaming, and educational in nature; it is not a time for you to talk about your feelings. More than anything, it is hoped that it will be a moment of self-discovery for the child.

- Is usually used near times of stress, strong emotions, or behavioral problems when there is not a concern that the situation will get out of control .
- Requires a number of interviews in order to produce significant changes; LSI interviews, like most other interventions, are cumulative in nature and contribute to changes in behavior over time.

Goals of the LSI are:

- To help the child regain or maintain emotional balance and self-control.
- To use a state of upset as an opportunity to develop self-awareness.
- To teach the child awareness of, management of, and the relationships among: emotions, thoughts, stressors, others' reactions, challenges and behaviors.
- To develop the relationship between you and the child.
- To provide you with insights about the child.
- To provide the child with your perspective on the situation.
- To develop appropriate and successful strategies for dealing with similar situations.
- To help the child assume responsibility for his/her actions
- To help the child develop self-esteem

Components of the LSI

- Quiet and Privacy –Best done when the child can focus on the task at hand and not be distracted by other people, noises, and events. You should not be afraid to spend an extended period of time with the child in silence.
- Listening and Learning – Allow the child the opportunity to express what happened. You can engage the child with statements such as "Can you tell me what happened?" or "Help me understand what was going on." It is critical that you get the child's perspective without judgment. Even if the child relates something that is not true, you must listen. You will have a chance to provide another viewpoint later but this moment is for hearing the child out. When you listen, even when both you and the child know what you are hearing is not accurate, you communicate respect and value. It is important that you be patient while the child formulates his/her thoughts or overcomes his/her unwillingness to share.
- Sharing your point of view – After the child has shared his/her viewpoint completely, you have the opportunity to share yours. The temptation is to go right after the child's "false statements" and correct them, but that is usually not helpful. You should be non-judgmental as you say what you saw, heard, thought, and felt. You can relate the feelings that you

experienced but you must claim these feelings as your own. The child may want to intervene and correct you as you talk but s/he must be reminded that s/he has had his/her turn.

- Drawing Relationships –After you have state your viewpoint, it is time to move on to the learning part of the process. You will help the child form some connections between:
  - Emotions and behavior
  - Past experiences and emotions
  - Current behavior and past patterns of behavior
  - Current behavior and the responses from others
  - Present actions and future consequences/expectations
- Brainstorming Alternatives – The basic intent here is to list as many alternative responses to the situation as the child can think of. Some will seem appropriate and some will not; some will be within the child's capacity and others will exceed his/her capacity. If the child struggles with this exercise, you can make some suggestions. After the list is made, you and the child can explore them together, discuss the pros and cons of each one, and choose the best one.
- Making plans – The child, with your help, formulates a plan for how he will deal with a similar situation the next time. The plan may include how you and other people will respond.
- Reintegration – The behavioral incident and the LSI will take the child away from the flow of events. S/he needs to know what is going on now and what s/he will be expected to do.

A useful tool for remembering the steps to the LSI is I ESCAPE.

I ISOLATE FROM SPACE
E EXPLORE CHILD'S VIEW
S STATE STAFF'S VIEW
C CONNECT BEHAVIOR AND FEELINGS
A ALTERNATIVE SOLUTIONS
P PLAN FOR RE-ENTRY
E ENTER SPACE

- Important Considerations
  - The best time to conduct the LSI is as close to the incident as possible, as the greatest learning takes place while the experience and feelings are still present on a conscious level.

- The adult who conducts the interview should be the person who was involved in the incident. This affords the opportunity, if needed, for the child to strengthen and/or repair the relationship with the adult.
- The child may have suffered some loss of self-esteem in the course of the incident. It is important to protect and rebuild his/her self-esteem during the LSI. Therefore, the tone of the interview needs to remain positive and full of hope.
- You must be aware of your own emotions at this time. This is an excellent time to practice and model emotional management strategies as part of the teaching process. Unconditional positive regard is an essential component of the LSI.
- Reminding yourself that the child is in the process of learning to meet his needs without infringing on the rights of others helps to focus the LSI on the teaching aspects of the activity.
- You don't give advice on how to better deal with the issues at hand.
- Dramatic results are not likely from a single conversation, but this approach is effective with repetition. Not every LSI will have a satisfying resolution. Patience is essential.

- Potential Problems
  - The child does not talk – Remember that many people have difficulty reasoning and processing language in the best of times. In times of stress, the challenge may be substantially increased. Provide plenty of time for thinking. Use active listening techniques to encourage expression and simplify the use of language.
  - The child talks a lot – Encourage exploration of relevant feelings, past episodes, and concerns. This is a time to learn about the sources of emotional upset. The child may be avoiding the subject at hand. Gently but firmly, guide the conversation to keep to the point. The child may find the attention gratifying. Try to find a balance between providing appropriate, supportive attention and making this process so rewarding that it encourages the behavior you wish to discourage.
  - You play too great a role – Remember that the more you contribute to the process, the less the child will learn and bear responsibility for it. It can be common for someone to become impatient with the process and with the child as they imagine that they have the insights needed or can perceive "obvious" resolutions and plans. To the extent that you may offer these prematurely, you deprive the child of the opportunity to experience insights and success in his/her own way and time. It is also

easy to assume what is going on with the child and to not listen patiently enough.

- SB-BHP Life Space Interview Checklist
  - Provided for quiet and privacy
  - Encouraged child, listened to him/her explain what happened
  - Shared his/her perception in a non-judgmental way
  - Drew connections between present and/or past behavior/stressors
  - Encouraged the child to brainstorm alternatives
  - Developed a plan to use the next time a similar event happens
  - Made sure the child understood the plan and consequences
  - Maintained a hopeful attitude during the interview
  - Modeled good anger management skills
  - Did not give advice

- The Life Space Interview with a non-verbal child
  You may work with a child who is non-verbal. The use of a Life Space Interview probably won't be helpful to the child. Gaining an understanding of the child's behavior will require a great deal of observation on your part. You will also want to learn as much as you can from the family and other providers about how the child communicates his/her needs. Keep in mind that the child is trying to communicate to you in his/her own unique language. It is you job to learn the child's language.

- Tips for Resolution
  - Maintain your Unconditional Positive Regard.
  - Remember you are teaching the child that s/he has options.
  - Remember to create safety for the child emotionally as well as physically.
  - Apologize when you are wrong.
  - Be ready to give the child a "thank you" for his/her efforts.

The SB-BHP should document the crisis as soon after the event as is feasible. S/he should be as thorough as possible in relating the details of what led up to the crisis, how it proceeded, and how it was resolved. This will enable the treatment team to have a more complete understanding of the child and the issues at hand. The SB-BHP should also set up a time to process the crisis during supervision. It is important for the SB-BHP to discuss his/her thoughts and feelings related to the crisis.

Recall a time when you were involved in a crisis. Describe the situation and how you responded. Identify your feelings, your automatic response. What did you do that was helpful? What would you do differently? What did you learn?_____

Competency

C The participant will demonstrate the use of reinforcement, modeling, redirecting and other learning strategies in teaching behavioral skills. (Level 2)

MOTIVATION

Motivation can be defined as a state of mind that energizes, directs and sustains behavior. Part of your job will be motivating the child to develop new behavioral skills.

A child's motivation is influenced by need. Maslow's Hierarchy of Needs shows that a child will be motivated by the next level of need when the previous need is met. For example, a child who has his/her physical needs met and feels safe will be motivated to work on social skills.

Motivation is also influenced by positive and negative consequences that are associated with a behavior. A child will be motivated to learn a new skill when s/he has lots of support and encouragement. When the child's progress is pointed out and celebrated, s/he is motivated to continue to work on the new skill. A child will not be motivated if the task is unpleasant or if s/he is worried about being able to do the task.

A child will be motivated to work on a new skill when it is connected to something s/he is interested in. S/he will be more likely to stick with the task even when it gets hard if some part of the task is holding his/her interest.

STRATEGIES FOR INCREASING MOTIVATION

Children want acceptance and approval from the important grown-ups in their lives. You will become an important person to the child. A child who feels respected will want to try and please you. Genuine enthusiasm can also be a strong motivator. Other informal motivational strategies are:

- Know the child's interests and use them to achieve the goal.
- Understand what that child thinks s/he can do.
- Plan for success, start with some part of the task the child can already do.
- Keep it simple.
- Lots of re-assurance, encouragement and praise, write a note, give a high five, or a wink.
- Encourage the child to take pride in his/her success.

Formal motivational strategies are:

- Behavioral contract –clearly states what the child should do, how it will be done and what the reward will be. A contract should also include the child's name, date it starts and stops, and a place for signatures. It can also include a statement about what will happen if the contract is broken, how a bonus can be earned or a daily check-off for successfully completing the contract.
- Goal setting – you and the child identify the small steps and set up goals for reaching them. Allowing the child to set the goals s/he will meet can increase feelings of ownership.
- Advertise success – you and the child might make a big gold star or a certificate and put it on the wall at school or refrigerator at home.

Make of list of words, phrases and non-verbal expressions of praise, encouragement and support.

PRAISE:

ENCOURAGEMENT:

SUPPORT:

MASTERY LEARNING

The ITP will identify the skills that you will be teaching the child. You will be helping the child to master a skill. Several assumptions are made about mastering skills. These are:

- A child will master skills and behaviors at his/her developmental level.
- Accommodations, type of assistance and time needed to master a skill will vary from child to child.

You and your supervisor will explore different methods of teaching skills. Some common elements in all teaching strategies are:

- Link new skills and information to what the child already knows and can do.
- Prior knowledge is key to a new skill or behavior.
- Task analysis – breaking the skill or behavior into small steps.
- Chaining – Determine the steps that the child is able to do. Master each individual step before moving on to the next. Identify measurable and observable criteria for determining when the step is learned. Make sure the child understands what s/he is expected to do. When those criteria are met, the child is ready to move on to the next step.
- Give positive feedback for each attempt the child makes to perform the task. Clear feedback about what the child is doing correctly and how to improve is essential for master a new skill or behavior.
- Mastering each step in the skill or behavior ensures that it will become automatic. The reinforcement becomes intrinsic.

There may be many situations in which you will be spontaneously teaching the child a skill. You will want to look for the "teachable moment"; situations where you can help the child use the skill or behavior in an unplanned way. And keep in mind you are a role-model, the child will watch what you do, so "practice what you preach".

TEACHING STRATEGIES

TASK ANALYSIS

You may be asked to break down a skill or behavior into all the steps that are required to successfully perform it. Breaking a skill or behaviors down into small steps is called a task analysis. It requires careful observation of what happens when the skill or behavior is performed successfully. Each step is identified and put in a logical sequence. The sequence starts with the most basic step first before moving

on to the more complex or difficult. The starting point may vary depending upon the skill level of the child. The steps of a task analysis include, but are not limited to:

- Identify the skill or behavior.
- Where it will be used?
- When it will be used?
- Why it will be used?
- A list of all the steps needed to perform the skill or behavior

When you are teaching the skill, you will teach one step at a time. You will start with a step that the child can already do. You may find that teaching the steps overlap and that you are teaching several steps together. It is best to limit the number of steps you teach at one time to three (3). Use the observable measure to show the child his/her progress. Pointing out to the child his/her accomplishments can be a strong motivator.

A complete understanding task analysis will help you take advantage of every opportunity to support the child's success in mastering a new skill. In your work there may be many skills or behaviors that you will do a task analysis of. You may want to start a task analysis notebook. The following is a format you may want to use.

Task Analysis Notebook

Skill: _____
Where skill is used: _____
When the skill is used:_____
Why the skill is used:_____
Equipment/tools used to perform skill: _____
Step 1: _____
Step 2: _____
Step 3: _____
Step 4: _____
Step 5: _____
Step 6: _____
Step 7: _____
Step 8: _____
Step 9: _____
Step 10: _____
Step 11: _____

Do a task analysis on the following:
Brushing your teeth: _____

Making a peanut butter and jelly sandwich: _____

UNDERSTANDING LEARNING STYLES

Everyone has a learning style. This is how a person learns new information or a skill. It will be important for you to understand you learning style and the learning style of the child. You need to be able to teach the child using the method that works for him/her. Presenting information in the child's learning style can be a motivator. There are four (4) learning styles:

- Visual – A child who is a visual learner acquires new information by watching something being done before s/he tries to do it. Looking at pictures, videos, diagrams, and maps or creating visual images may help him/her. Watching other children and the SB-BHP perform the skill may be essential for a visual learner. A child who relies on visual cues for learning may seem reluctant to try a skill until s/he has seen it repeated enough times. A clue that a person is a visual learner is s/he will say "I see …" when s/he comprehends what is being conveyed.
- Auditory – A child who is an auditory learner takes in information by listening. S/he learns best when s/he can hear instructions or information. A child who is an auditory learner may not appear to be paying attention when spoken to because s/he is processing what is being said. A clue that a person is an auditory learner is s/he will say "I hear …" when s/he comprehends what is being conveyed.
- Kinesthetic – A child who is a kinesthetic learner acquires new information by doing. S/he learns best when engaging in hands on or hand-over-hand instruction. A child who is a kinesthetic learner may display impatience with instructions and demonstrations because s/he needs to be in direct contact with the information. A clue that a person is a kinesthetic learner is s/he will say "I get …" when s/he comprehends what is being conveyed.
- A Combination – Some children's learning style is a combination of visual, auditory and kinesthetic learning. A clue that a person has a combined learning style is s/he will use one of the phrases above when s/he comprehends what is being conveyed. The phrase s/he uses will depend upon the situation and how s/he is taking in the information. A child might say "I see, yeah, I get it."

Identify your learning style: _____

_____

Identify the learning style of a child you work with: _____

_____

DIFFERENT KINDS OF INTELLIGENCE

Howard Gardner, in Frames of Mind, describes seven (7) different kinds of intelligences. Some people are very gifted with words; others are skilled athletes, while others understand people. You will want to notice what the child does naturally, the things that are easy for him/her to do. Those things will be part of the child's intelligence and you will use them to help him/her learn new things. The seven kinds of intelligences are:

- Linguistic – structure of language, involves reading, writing, listening and speaking
- Logical-Mathematical – assessing objects, ordering/re-ordering, relationship to each other, actions one can perform and the realm of pure abstraction of ideas
- Musical – awareness of sounds, tones, pitch, timber and rhythms
- Spatial – seeing objects from different angles, visualizing movement and relationships of objects
- Bodily-Kinesthetic – superb control of bodily motions and skillfully works with objects
- Interpersonal – discriminating feelings, thoughts of others, even when hidden or disguised
- Intrapersonal – awareness and understanding of one's inner life, thoughts, feelings, motives

TEACHING STRATEGIES

TELL – SHOW – DO is a good way to teach a skill or behavior. It can be used in a structured setting or in spontaneous situations. In this method you are telling the skill that s/he will learn, you show him/her how to do it and then you ask the child to do it.

Your first step will be to make sure the child is interested in learning the skill or behavior. Tell the child all of the steps s/he needs to do. It is best if the steps are taught three (3) at a time. Show the child how to do each step, explain what you are doing as you move through the steps. Then ask the child to do the steps. Be prepared to repeat the process several times. Pay close attention to what the child does right and encourage him/her to master the entire skill or behavior.

Once you have completed any teaching strategy you should evaluate your effectiveness. Some questions you might ask yourself are:

- Did I remember to use the child's learning style?
- Did I break the skill down into manageable steps?
- Did I give clear directions?
- Did I give the child clear feedback?

OTHER TEACHING STRATEGIES:

Social Stories are a method for teaching social skills. Social behaviors are taught by using stories. These stories are read to the child and used to practice a skill or as a rehearsal tool before engaging in a social activity. Social stories, like a task analysis, break down a social situation into all of the steps a child will need to do. The stories should be developed by someone who as experience in order in ensure that all of the information in the story is what you want the child to learn.

Applied Behavioral Analysis (ABA) is a highly structured system used to change behavior. An ABA program for changing behavior is developed by a certified professional. You may be asked to participate in some part of the program. You will need to get clear instructions from your supervisor about what you will do with the child to help him/her change his/her behavior.

Self-Management – is a method to support personal autonomy. There are three (3) components: Self-Monitoring - teaches the child to become aware of his/her behaviors, Self-Evaluation – teaches the child to notice whether or not s/he performed the behavior, Self-Reinforcement – teaches the child to identify successes and select a reward for achieving them. This approach uses a range of teaching techniques.

- Modeling – formally or informally showing how to perform a skill
- Rehearsal – acting out a skill in a safe setting
- Shaping – using reinforcements to support developing a skill
- Prompting – directing verbally or non-verbally to perform a skill
- Feedback – pointing out what worked and didn't work and why, offering suggestions
- Generalization – connecting the skill to related situations

TEACHING THE NON-VERBAL CHILD

When you work with a non-verbal child, you use all of the same teaching principles that have been discussed. Keep in mind that the presence or lack of verbal language is not an indicator of intelligence. A child may lack the ability to use words and may be very intelligent. When you teach a skill to a non-verbal

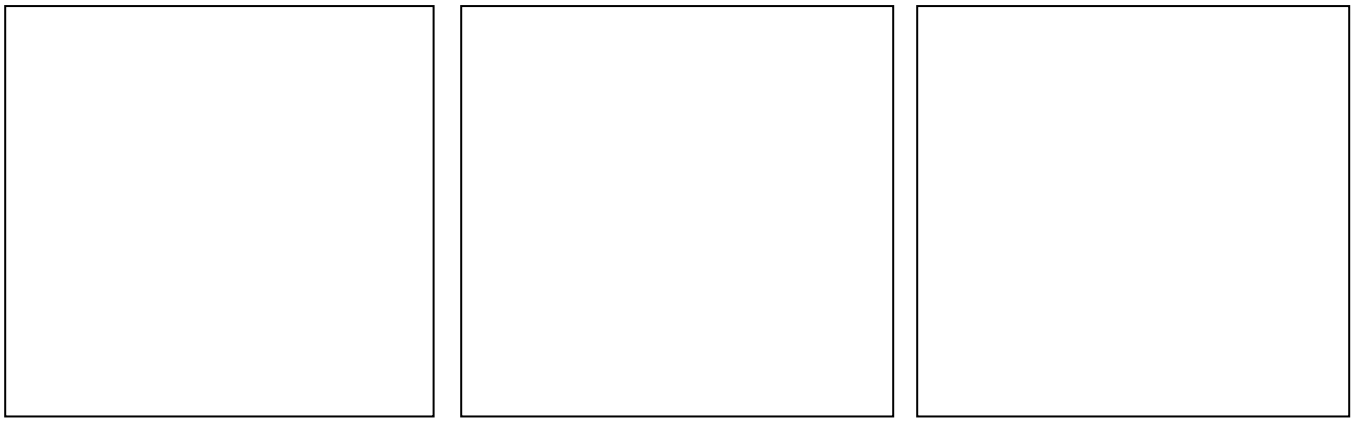
child, you will need to learn the child's language. S/he might use a structured communication system such as Picture Exchange Communication (PECs), sign language, a communication board or the child and family may have developed a unique method of communication. Learning any new language takes time. You will have to put considerable effort into making sure you can communicate in the child's language.

You need to pay careful attention to the child's frustration level. A child who is unable to have her/his needs, wants, thoughts, feelings and ideas understood and responded to will become frustrated. A child who is frustrated may act out or become disengaged. Your responsibility is to increase skill and decrease frustration.

In addition to having a good working alliance with the child, some of the things you can do to support a non-verbal child's learning are:

- Make sure the pace of the communication fits with the child's abilities.
- Check in frequently to be sure the child is understood and understands what is said.
- Always use the child's language or signs.

Create a three (3) picture sequence for buckling a seat belt. Start with the person seated in the car:



Competency	
D	The participant will demonstrate knowledge of strategies for assisting the child in networking with peers. (Level 1)

NETWORKING WITH PEER RELATIONSHIPS

Friendships and peer relationships are very important. These relationships can be challenging for a child with a disability. The development of peer relationships may be a goal in the child's ITP. The goal might focus on individual or group relationships or possibly both.

The type of social interaction we have with people depends on the situation and how familiar we are with the people. Our conversations with strangers are generally superficial as opposed to the intimate conversations we have with a best friend or loved one. The same holds true for group interactions. The purpose of the group and familiarity the members have with each other will affect the level of intimacy among the members.

The child may have difficulty forming and maintaining friendships. These relationships cannot be forced. They should be based on mutual interests, shared experience and liking the person. You should follow the child's interests when selecting activities that could foster friendships.

There may be opportunities to use a group setting or activity to teach the child appropriate social skills. Some things to keep in mind when using a group are:

- Plan the activity with the child, parent(s) and Supervisor.
- Keep the group small with only the child and one or two peers.
- Have several things for the children to do.
- Do warm-ups and role-play with the child.
- Think ahead and identify where there may be problems.
- Hang back, follow the child's lead and give support when needed.
- Talk with the child after the activity and point out the things that worked well and ways for the child to improve.

You will be a role model for the child as s/he learns how to interact with strangers, acquaintances and friends. The interactions with peers in different community

settings will help the child build on their social, problem solving, and conflict management skills.

And last, but not least, help the child to have FUN! Find as many ways as you can, big and small, for the child to have a positive experience. All of us learn best when we have fun, get positive feedback, and can see our achievements.

The child may not know what traits or attributes children like about other children. A survey was conducted by Fox and Weaver* to gather information about what children like about other children. The following are the results:

- Things Kids Like About Other Kids

BOYS	GIRLS
Athletic	Personality
Honest	Similar Interests
Responsible	Sense of humor
Personality	Friendly
Similar Interests	

- Things Kids Dislike About Other Kids

BOYS	GIRLS
Trouble maker	Stuck-up
Pushy	Unfriendly
Bossy	Unkempt
Dumb	

- What Do Kids Look for in the Opposite Sex

BOYS	GIRLS
Appearance	Appearance
Personality	Personality
Loyal	Kind
Caring	Loyal
Smart	
Confidential	
Athletic	

- What Do Kids Talk About

BOYS	GIRLS
Girls	Boys

Sex	School
Sports	Gossip (what others are doing)
"Safe" Topics	Private Things

- General Positive Traits Kids Like About Other Kids

  Smile/Laugher
  Greeting others
  Extending invitations
  Converses
  Shares
  Compliments
  Good Appearance

- Teacher Pleasing Behaviors

Be on time	Eye contact
Participate	Use teacher's name
No slouching, sprawling	Submit work on time
Use required format	Avoid crossing out
Request explanation	Leave after the bell
Say "Thanks"	

* Presented by Rick Lavoie, "Last one Picked … First one Picked On: The Social Implications of Learning Disabilities", Portland, ME November 8, 2002.

Using the "What Kids Like About Other Kids" list above, identify two (2) things you could help the child you work with do to increase the likelihood that s/he will be liked by his/her peers.

_____
_____
_____
_____
_____
_____